



**FIELD TRIP/VOLUNTARY ACTIVITY PERMISSION FORM
AND EMERGENCY MEDICAL AUTHORIZATION - MINOR**

Unified School District

The Field Trip/Voluntary Activity and the Emergency portions of this form must both be completed.

FIELD TRIP/VOLUNTARY ACTIVITY INFORMATION		<i>This portion is to remain in the school office.</i>
FIELD TRIP/ACTIVITY GROUP (GRADE, LEVEL, CLASS, ETC.)	DATE OF FIELD TRIP/ACTIVITY (DAY, WEEK, & DATE)	
TIME OF FIELD TRIP/ACTIVITY (FROM / TO)	COST OF FIELD TRIP/ACTIVITY	
LOCATION OF FIELD TRIP/ACTIVITY (NAME AND CITY)		
PURPOSE OF FIELD TRIP/ACTIVITY		

TRANSPORTATION FOR FIELD TRIP OR ACTIVITY WILL BE PROVIDED BY:

<input type="checkbox"/> ELK GROVE SCHOOL BUS	<input type="checkbox"/> OTHER ELK GROVE DISTRICT VEHICLES	<input type="checkbox"/> PRIVATE CAR
<input type="checkbox"/> COMMERCIAL TRANSPORTATION	<input type="checkbox"/> WALKING	<input type="checkbox"/> OTHER _____

IMPORTANT NOTICE: California Law provides as follows: "All persons making the field trip or excursion shall be deemed to have waived all claims against the District or the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion." (Education Code §35330).

PARENT/GUARDIAN AUTHORIZATION			
<i>My son/daughter has my permission to participate in the field trip or activity described above.</i>	NAME OF STUDENT		STUDENT #
SIGNATURE OF PARENT/GUARDIAN		DATE	
PRINTED NAME OF PARENT/GUARDIAN	CELL PHONE #	HOME PHONE #	WORK PHONE #

cut along dotted line

ELK GROVE UNIFIED SCHOOL DISTRICT	<i>This portion is to be carried by teacher on field trip.</i>
FIELD TRIP/ACTIVITY EMERGENCY INFORMATION	
NAME OF STUDENT	DATE OF FIELD TRIP

EMERGENCY ACTION

INDICATE THE EMERGENCY ACTION DESIRED IN THE EVENT OF AN ACCIDENT OR EMERGENCY, CHECK BOX #1 OR #2, AND IF APPLICABLE, #3. SIGN AND DATE WHERE INDICATED.

#1 In the event of an accident or other emergency when a parent/guardian is unavailable, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment of my child as he/she considers necessary. In the event said physician is not available at any time, I authorize such care and treatment to be performed by any licensed physician or surgeon. **THE UNDERSIGNED PARENT/GUARDIAN FULLY UNDERSTANDS HE/SHE IS RESPONSIBLE TO PAY ALL COSTS INCURRED AS A RESULT OF THE FOREGOING.**

PHYSICIAN'S NAME	PHONE #
MEDICAL INSURANCE CARRIER	POLICY/ID#

#2 I do not choose the above statement and desire the following action:

#3 My son/daughter has the following medical condition:

My signature indicates that I have read and understand this form and that the information provided is true and correct to the best of my knowledge.

SIGNATURE OF PARENT/GUARDIAN			DATE
PRINTED NAME OF PARENT/GUARDIAN	CELL PHONE #	HOME PHONE #	WORK PHONE #