COVINA-VALLEY UNIFIED SCHOOL DISTRICT

STUDENT PARTICIPATION IN VOLUNTARY FIELD TRIP
PARENTAL PERMISSION, ASSUMPTION OF RISK, AND
MEDICAL TREATMENT AUTHORIZATION

Date All Local Events from June 9, 2024.-June 8, 2025

***STUDENT NAME**: _____ has permission to participate in the following field trip:

Destination/Nature of Activity: **All Local Events from June 9, 2024-June 8, 2025**
(Please be specific, i.e. Concert at UCLA)

Special Instructions: **See Itinerary Found On Website**
(i.e. bring a jacket, lunch money)

Departure Date: **TBA** Time: **TBA** Return Date: **TBA** Time: **TBA**

Person in Charge: Mike Wooten Position: Director School: South Hills

Type of Transportation: (X) School Bus/Vehicle ( ) Walking ( ) Other: _____

HEALTH OR SPECIAL NEEDS: MUST BE CHECKED AS APPROPRIATE
( ) My student has no special health needs the staff should be aware of, and no medication is required on the trip.
( ) My student has a special need, and/or medications and instructions are attached. # of attached pages ____.
( ) Other: _____

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

As provided for in California Education Code Section 35330, I agree to waive all claims against the Covina-Valley Unified School District (District) and hold the District, its officers, agents and employees, harmless from any and all liability or claims, which may arise out of or in connection with my child's participation in this activity. This waiver shall not apply to any occurrences, which may arise solely out of the negligence of the District, its employees or agents.

_____ _____ Work Phone _____
***Parent/Guardian Signature** **Print Name** Home Phone _____
Cell Phone _____

_____ _____
Student's Signature Student's Date of Birth

Family Medical Insurance Carrier (if applicable): _____ Policy #_____
Expiration Date_____

***In the event of an emergency, please contact**:

_____ _____ Work Phone _____
Emergency Contact Name Relationship Home Phone _____
Cell Phone _____

_____ _____ Work Phone _____
Emergency Contact Name Relationship Home Phone _____
Cell Phone _____

OFFICE USE ONLY
Health Clerk signature_____ Date_____

02/08 Business Services