

REDONDO BEACH UNIFIED SCHOOL DISTRICT
Office of Instructional Services

STUDENT PARTICIPATION IN DISTRICT-SPONSORED VOLUNTARY STUDY TRIP
PARENTAL PERMISSION, ASSUMPTION OF RISK, AND MEDICAL TREATMENT AUTHORIZATION

Student's Name: _____ has permission
(First & Last)

to participate on 11/14/18 in the following field trip:
(Date of study trip)

Destination/Nature of Activity: OC Water District Groundwater Replenishment
(Please be specific, e.g., Trip to _____ Museum)

Special Instructions: Bring a snack + lunch
(e.g. Bring a sack lunch)

Departure Date: 8:30 Time: 11/14 Return Date: 11/14 Time: 3:00 pm

Person in Charge: Gillian Moberg Position: APES teacher School: RUHS

Type of Transportation: School Bus/Vehicle Walking Other: _____

Health or special needs: (Check 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 instructions are attached. Number 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.

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip.

As provided for in California Education Code Section 35330, I agree to waive all claims against the Redondo Beach 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.

_____ Signature of Parent/Guardian	_____ Please Print Name	_____ Wk #
		_____ Hm #
_____ Signature of student	_____ Student's Date of Birth	_____ Wk #
		_____ Hm #
_____ Medical Insurance Carrier (e.g. Blue Cross, Kaiser)		_____ Policy Number

In the event at an emergency, please contact:

_____ Name	_____ Relationship	_____ Wk #
		_____ Hm #

Contact your Student's school regarding sack lunches for study trips.