

Reed Union School District

Field Trip Notice and Medical Authorization

Please complete and return this signed form to your child's advisor. Advisor Name: _____

Student Name: _____ has my permission to participate in the following activity:
Last day of school field trip to Scandia in Rohnert Park

Teacher/Room Sixth Grade Team Destination: Scandia Family Fun Center, Rohnert Park

Departure date & time Thursday, June 14th at 8:45am Return date & time Thursday, June 14th at 1:30pm

I understand that my child will be traveling by: bus

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 are considered necessary in the judgment of attending physician, surgeon, or dentist and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

As stated in California Education Code Section 35330, I understand that I hold the Reed Union School 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.

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip. Any violation of these rules and regulations may result in that individual sent home at the expense of his/her parent/guardian.

Student Signature _____

Date of Birth _____

Parent/Guardian Signature _____

Date _____

Address _____

Phone _____

Medical Insurance Carrier _____

Policy # _____

Address _____

ALL medications must be registered on this form. All medications, excepting those, which must be kept on the student's person for emergency use, MUST be kept and distributed by staff.

Check here if there are no special problems that the staff should be aware of and no medications are required on the trip.

Check here if any medications are to be taken by this student. Attach a description of that medical problem to this form.

Name of medication and reason _____