Mission Basilica School Field Trip Parent Permission Form

ADVISOR: Mrs. Sonia Barriga _____ GROUP: Swallow's Day Parade
DESTINATION: City of San Juan Capistrano START TIME: 9:00am RETURN TIME: 12:00pm
DATE OF TRIP: Saturday, March 25, 2023 FEE: None
MODE OF TRANSPORTATION: Walking
LUNCH ARRANGEMENTS: None. OBJECTIVE: Swallow's Day Parade
ATTIRE: **Jeans, polo or spirit shirt, walking shoes, cowboy hat and sun screen**
KINDERGARTEN ONLY – MONK COSTUME
1ST GRADE ONLY – SWALLOW COSTUME
CHEERLEADERS – CHEER UNIFORM
ROYAL COURT – COURT COSTUME

I/we hereby request that_____participate in the trip to **Swallow's Day Parade**
Student Name (please print)
I/we give my/our consent and understand that supervision and/or transportation for this event will be provided and that all diocesan and school policies will be strictly adhered to. I/we agree to direct my son/daughter to cooperate and conform with the directives and instructions of the supervisory personnel in charge of the activity.

STUDENT MEDICAL RELEASE

I/we, the parent(s)/guardian(s) of the above named student, hereby, give my/our permission for his/her participation in the activity named above. I/we am/are not aware of any medical condition of my child which would render it inappropriate for him/her to participate in any such activity.

Should it be necessary for my/our child to have medical treatment (including dental or hospital treatment) on this trip, I/we hereby give the school personnel permission to use their best judgment in obtaining medical service for my child, and I/we give permission to the physician selected by the school personnel to render medical treatment deemed necessary and appropriate by the physician.

I/we agree that in the event my/our child is injured as a result of his/her participation in the above named activity, including transportation to and from such activity, whether or not caused by the negligence (active or passive) of the school or any of its agents or employees, recourse for the payment of any resulting hospital, medical, dental treatment or related costs and expenses will first be had against any accident, hospital, medical or dental insurance, or any available benefit plan of our family.

Parent / Guardian Signature:_____ **Parent/Guardian Signature:**_____

(Home Phone Number)_____ **(Cell Phone Number)**_____

(Work Phone Number)_____ **(Date Signed)**_____

Insurance Company_____ **Policy Number**_____

Doctor's Name_____ **Phone Number**_____

Allergies/Medical Problems/Disabilities_____

Student Date of Birth_____ **Age**_____

Parents' Email Address(es)_____