CHICO UNIFIED SCHOOL DISTRICT
1163 E. Seventh Street
Chico, CA 95928
530-891-3000

ADMINISTRATION
REGULATION
6153

PERMISSION FOR SCHOOL-SPONSORED VOLUNTARY ACTIVITY AND CONSENT TO MEDICAL TREATMENT - MINOR

Please complete and return form to: _____ SCHOOL

(Name of Child)_____ has my permission to participate in the

voluntary activity of _____

DESTINATION _____

DATE_____TIME OF DEPARTURE_____ DATE/TIME OF RETURN _____

TRIP SUPERVISOR _____

MEANS OF TRANSPORTATION: (Please check one)

- ☐ District-owned vehicle
- ☐ Commercial (Name of company) _____
- ☐ _____ Other (Specify) **NOTE: It is fully understood that CUSD is in no way responsible, nor does CUSD assume liability, for any injuries or losses resulting from non-CUSD sponsored transportation, although CUSD may assist in coordinating the transportation and/or recommend travel time, routes, or caravanning to or from this event, it is not mandatory. Driver is not driving on behalf of nor is an agent of CUSD.**

AS STATED IN CALIFORNIA EDUCATION CODE SECTION 35330, I understand that I hold Chico Unified School District, its elected or appointed officials, employees, agents, and volunteers 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 being sent home at the expense of his/her parent/guardian.

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 best judgment of the 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.

A SPECIAL NOTE TO PARENT/GUARDIAN: (1) If any medication or drugs are to be taken by student, such medications must be listed below. (2) All drugs must be kept and distributed by the staff. (Name of drug and reason)

_____

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW: _____

_____

Date of Last Tetanus Toxoid Booster _____

Parent/Guardian Signature: _____ Date: _____

Address: _____

EMERGENCY TELEPHONE NUMBER: _____ ☐ Home ☐ Work ☐ Cell

Medical Insurance Carrier_____ Policy No. _____