TALENT BANK VOLUNTARY FIELD TRIP PERMISSION SLIP AND PARENT INFORMATION

PARENT: Keep this part as a reminder.

SCHOOL ________________________________ DATE ________________________

A Field Trip has been planned to ____
(Destination)

Date of the Field Trip ____

Cost of the Field Trip ____

CHECKS OR MONEY ORDERS PREFERRED! (Payable to Talent Bank)

Teacher in Charge is ____

Departure Time ____________________ Approximate Return Time __________________

Transportation will be by:

1. __________ Chartered Bus

2. __________ Individuals 18 years of age or older who are not employees of the District in Privately-Owned Vehicles.

3. __________ Other (NOTE: If transportation Option 2 is used, a driver's "Private Automobile Liability Insurance Certification" will be on file with the school office).

Sack Lunch is needed: YES __________ NO __________

PARENT: Your child must return this part with both sections signed prior to the trip in order for your child to be included.

Name of Child (Please Print) ____

Destination ______________________________ Date of Trip ______________________

I hereby give consent for my child to go on this field trip, and I accept responsibility for any damage or injury caused by my child to persons or property of either the San Marino Unified District or a third party. If for some unavoidable reason the trip is postponed, I agree this authorization will be applicable to the same trip at another time. I understand that under Section *35330* of the California Education Code, I hold the San Marino Unified School District, its officers, agents and employees harmless from any liability or claims, which may arise out of or in connection with my child's participation in this activity. If necessary, I agree my child may be transported back to school by Privately-Owned Vehicle.

______________________________ ______________________

(Signature) (Date)

CONSENT FOR RENDERING OF MEDICAL SERVICES

In the event of illness or injury, I do hereby consent to whatever x-rays, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the 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.

______________________________ ______________________

(Signature) (Date)

Home Phone Number ____________________ Work Phone Number ____________________

Medical Insurance Carrier ______________________________ Policy No. __________________