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

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

Please complete and return this form to: _____ SCHOOL

(Name of Child)_____ has my permission to participate in this voluntary activity:

Activity/Destination: _____ Trip Supervisor:_____

DATE(S) OF ACTIVITY:_____TIME OF DEPARTURE:_____ TIME OF RETURN: _____

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.

Parent/Guardian Signature: _____ Date: _____

EMERGENCY PHONE NUMBER: _____ **ADDITIONAL EMERGENCY PHONE NUMBER:** _____

MEDICATIONS:

(1) ***All drugs (including 'over-the-counter' medications) must be kept and distributed by staff.***
(2) ***Medications must be in original container.***
(3) ***Medications require doctor's note or 'Authorization to Administer Medication' form*** *(HS-11a)* ***on file at school.***
(4) Please list any medication to be taken by student while attending this activity: **(Name of drug/reason for use):**

_____

PLEASE LIST MEDICAL CONCERNS: (Diabetes? Allergy? Asthma? Sleep Walking? Other health concerns?)

_____

_____

Does your student require special meals? _____ Date of last Tetanus Booster:_____

Is your child current on all California Immunizations required for school entry?_____ If no, please explain:

_____

Physician: _____ Physician's Phone: _____