

ST. ANNE'S ANNIES ANGELS
FIELD TRIP PERMISSION FORM

Student Name _____ **Grade** _____

Date(s) of Field Trip: September 2014 through May 2015
Purpose of Field Trip: Annie's Angels Shelter Dinner
Destination: Salvation Army Hope Harbor/622 N. Sacramento, Lodi, CA
Method of Transportation: Parent
Teacher/advisor/chaperone: Robin Precissi

I, the undersigned, parent or legal guardian of the above-named student, request that he/she be allowed to participate in, and give my permission for his/her participation in, those school activities described on the reverse and initialed by me. I hereby release and save harmless the school and any and all of its employees from any and all liability for any and all harm arising to my child and for any loss of property as a result of those activities.

Permission is given for the student named above: (please initial appropriate space)
_____ to be a passenger when an adult will be driving

MEDICAL PERMISSION FORM

I, the undersigned, parent or legal guardian of _____, a minor, do hereby appoint teacher/advisor and/or chaperone as agent(s) for the undersigned for the purpose of authorizing and signing any consents for any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of nearest Emergency Hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which any physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the California Civil Code and shall remain effective from _____ to _____ unless sooner revoked in writing to said agent(s).

parent / legal guardian signature (date)

(address) (city) (zip)

NECESSARY MEDICAL INFORMATION:

1. Full name of child _____ 1a. date of birth _____
2. In case of accident, call _____ 2a. home telephone _____
Home address _____ work telephone _____
3. Alternate person to call _____ 3a. telephone _____
4. Physician's full name _____ 4a. telephone _____
5. Family insurance policy _____ 5a. policy number _____
6. Describe in full any allergies (drug, food, insect bites, etc) or limitations on physical activity:
Drug allergies: _____
Food allergies: _____
Other allergies: _____
Physical limitations: _____