## **ST. MARY'S HIGH SCHOOL** FIELD TRIP PERMISSION SLIP

| Student Na  |   |  | Grade  |
|---|---|--|--|
| Date(s) of F  | Field Trip:   |  |  |
| Purpose of  | Field Trip:   |  |  |
| Destination   |   |  |  |
| Method of   | Transportation:   |  |  |
| Cha   | arter Company:  |  |  |
| Tea   | acher/Advisor/Chaperone   | •  |  |
| allowed to<br>activities d<br>defend Sai<br>their emplo<br>my child o<br>trip, regard     | o participate in, and g<br>described above and ini<br>int Mary's High School<br>oyees, agents or succes<br>or any harm occasioned | ive my permission for his/<br>tialed by me. I hereby relead<br>and indemnify Saint Mary<br>ssors from any and all liabil<br>by my child as a result of r | med student, request that he/she be /her participation in, those school is and save harmless, and agree to is High School, and any and all of lity for any and all harm arising to my child's participation in the field part of St. Mary's High School, its |
| to  | is given for the student n<br>be a passenger when adultravel by public or charte  | · —  | propriate space) _to drive his/her own car   |
| I, the under<br>teacher/adv<br>signing any<br>and hospita<br>any physici<br>staff of near | consents for any x-ray care which is deemed a care which is deemed a care and surgeon licensed                                    | ardian ofs agent(s) for the undersigned examination, anesthetic, mediandvisable by and is to be rend under the provisions of the                         | a minor, do hereby appoint d for the purpose of authorizing and cal or surgical diagnosis or treatment ered under the general supervision of Medical Practice Act on the medical atment is rendered at the office of said                                    |
| hospital car<br>agent(s) to   | re being required but is give specific consent to   | given to provide authority and   | any specific diagnosis, treatment or<br>d power on. the part of our aforesaid<br>treatment or hospital care which any<br>able.   |
|   |   |  | 5.8 25.8 of the California Civil Code voked in writing to said agent(s).   |
| Parent/Lega   | al Guardian signature   | (Date)   |  |
| (Address)   |   | (City)   | (Zip Code)   |
| NECESSAR  | RY MEDICAL INFORMA  | ATION:   |  |
| 1.  | Full name of child:   |  | 1a. Date of birth:   |
| 2.  | In case of accident call:   |  | 2a. Home telephone:  |
| 3.  | Home address  |  |  |
| 4.  | Alternate person to call:   |  | 4a. Telephone:   |
| 5.<br>6.  | Physician's full name:  |  | 5a. Telephone:   |
| 6.<br>7.  | Family Insurance Policy   | rug, food, insect bites, etc) or lim   | 6a. Policy number:   |
| 7.  | Drug allergies:   | nug, 100u, msect ones, etc) of IIII  | manons on physical activities.   |
|   | Food allergies:   |  |  |
|   | Other allergies:  |  |  |
|   | Physical limitations:   |  |  |