

California Montessori Project  
Field Trip Permission Slip & Emergency Information

Due with Specified Payment by \_\_\_\_\_

<b>Payment:</b> Date: _____ Cash: \$ _____ Check: # _____ Verified: _____ Coordinator's initials: _____
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Classroom: \_\_\_\_\_ Field Trip Destination: \_\_\_\_\_

Date: \_\_\_\_\_ Departure Time: \_\_\_\_\_ Return Time: \_\_\_\_\_ Lunch: \_\_\_\_\_ (Pack a disposable lunch & water bottle)

Cost per Student\*: \$ \_\_\_\_\_ Cost per adult: \$ \_\_\_\_\_

*\*CMP Policy provides that no student shall be excluded from a field trip for financial reasons.*

Please Note Siblings are not permitted on CMP Field Trips except in extenuating circumstances and parents are required to have at least 2 weeks prior approval. Siblings enrolled in CMP are expected to be in attendance in their own classrooms.

**Student Information:** My child, \_\_\_\_\_,  **does** /  **does not** have my permission to participate in the field trip listed above and to be transported by a CMP parent volunteer driver.

\_\_\_\_ My child requires a car booster seat! (required for child until 8 years old or 4'9" in height). Parents to leave seat with teacher.

**Parent Information:** Parent/Guardian Name(s): \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Volunteer and/or Driver Participation:**

\_\_\_\_ **Yes, I, (driver name) \_\_\_\_\_ would like to drive on the field trip, and can accommodate children, including my own child, in my car with seat belts and car seats if necessary.\***

I have been cleared by the school office to drive on fieldtrips by attending "7 Habits of Highly Effective Volunteers" and by submitting my Live Scan, TB test results, driving report, proof of insurance, driver's license and vehicle registration and am 25 years of age or older.

\_\_\_\_ **Yes, I, (chaperone name) \_\_\_\_\_ would like to volunteer on the field trip.\***

I have been cleared by the school office to volunteer on fieldtrips by attending "7 Habits of Highly Effective Volunteers" and by submitting my Live Scan and TB test results and am 21 years of age or older.

\_\_\_\_ **No, I am not able to participate on this field trip.**

*\*I understand there may be more volunteers and/or drivers than are allowed on the field trip and I will be notified if I will be driving or participating.*

**AUTHORIZATION TO TREAT MINOR:** In the event that I, or other parent/guardian, cannot be reached in an emergency, I hereby give permission to the school staff or designated parent supervisor to secure proper treatment for my child. 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 the medical staff of the hospital or facility furnishing medical or dental services.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important Notice:** California Law provides as follows: All persons making the field trip or excursion shall be deemed to have waived all claims against the school, district, or the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion (Education Code Section 35330).

**EMERGENCY INFORMATION: MUST BE COMPLETED to accompany your child's chaperone/driver**

Print Name(s) of Parent/Guardian: \_\_\_\_\_

Parent/Guardian Work Phone: \_\_\_\_\_ Pagers/Cell Phones: \_\_\_\_\_

Additional Emergency Contact Person/Relationship: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Additional Emergency Contact Person/Relationship: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Physician/Health Insurance Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's Critical Medical Needs/Allergies/Conditions: \_\_\_\_\_

# SACRAMENTO STATE **AQUATIC CENTER**

## W.E.T. Contract, Indemnification, Release and Waiver

Sacramento State Aquatic Center Water Enrichment Training "W.E.T"(Team Building) program includes physically and emotionally demanding activities. We want to make sure you understand the risk of injury before you decide to participate. It is required that you read the following **Legal Document**, very carefully, make sure you understand it, fill in all the spaces, and sign it before you, or your child begin our program. **No person or child will be allowed to participate without the properly filled out waiver and medical release forms.**

**PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING BELOW.  
THIS AGREEMENT INCLUDES A RELEASE OF CLAIMS.**

I am aware in signing this statement for participation in the Aquatic Center's **W.E.T. Programs** that certain elements are physically and emotionally demanding. This program may include swimming, paddling, crawling, jumping, climbing, and other rigorous activities (i.e. sailing, windsurfing, canoeing, kayaking, rowing, water skiing, jet skiing, and beach games) on the water or on the land. My child or I may be working with Aquatic Center Instructors and with others in their group. It is possible that we may be injured while participating in the W.E.T. activities either because of our own conduct, conduct of others in the group, conduct of ASI Aquatic Center instructor, or the condition of the premises.

Therefore, we voluntarily elect to allow my child or I to participate and I affirm that we are free of health conditions that might create undue risk to myself, my child or others that depend on them. My child and I are not under a physicians care for any undisclosed condition that bears upon our fitness to participate.

I agree to indemnify and hold harmless ASI Aquatic Center, their agents and employees from all claims, damages, losses, injuries and expenses arising out of or resulting from participation in the W.E.T. Programs. I further agree to release, acquit and covenant not to sue ASI Aquatic Center, for all actions, causes of action claims or damages, damages in law or remedies in equity of whatever kind.

I agree to the site of any lawsuit and the law governing any such lawsuit shall be California and governed by California law. As liquidated damages, I hereby agree that if ASI Aquatic Center is forced to defend any action, lawsuit or litigation by myself, my executors, my heirs or on my families behalf, my heirs or executors and I agree to pay ASI Aquatic Center costs and attorney fees if they successfully defend such action, lawsuit or litigation. In signing this document for my minor child I agree to pay any and all cost and attorney fees incurred by Aquatic Center in the event that the Aquatic Center is forced to defend any action, lawsuit, or litigation brought by my minor child.

The terms of this agreement shall continue and be in effect after the camp is over. Should any paragraph or part of this agreement be declared unenforceable by a court of competent jurisdiction the remaining paragraphs or parts shall remain in full force and effect.

I authorize and release to ASI Aquatic Center the use of any photographic or video recorded image for any purpose of the participant listed below.

I have adequate health, disability and life insurance for myself, and my family.

I hereby give permission for transportation to any medical facility or hospital, and I authorize for any qualified instructor or medical personnel to render necessary emergency medical care for the participant listed below.

I, \_\_\_\_\_, of my own free will, for my family, my minor children, my heirs and executors and myself, have read, understand and acknowledge the risks and liability for myself and my family this \_\_\_\_\_ day(s) of \_\_\_\_\_ (month) 200\_\_\_\_.

**(Date above must be the date of the W.E.T. program)**

\_\_\_\_\_  
Participant (print name)

\_\_\_\_\_  
Guardian (print name)

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

*(Parent or legal guardian must sign for all persons under 18 years of age. Proof of age may be required)*



# Aquatic Center Medical Consent Form



Participants Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Contact #: \_\_\_\_\_ home \_\_\_\_\_ work \_\_\_\_\_ cellular \_\_\_\_\_  
 Email Address: \_\_\_\_\_

Are you comfortable in the water? \_\_\_\_\_ Can you swim? \_\_\_\_\_

In case of an emergency whom should we notify?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Should there be any limits on physical activities? If so what are they? \_\_\_\_\_

Do you have any pre-existing conditions that will prevent or hinder your participation in the W.E.T. activities? If yes please explain: \_\_\_\_\_

Are you currently taking any medications? If yes please list: \_\_\_\_\_

Do you have any allergies or reactions we should know about? (i.e. bee stings, sulfa drugs, food)

Name of Insurance Carrier	Insurance Company Phone Number	Patient Medical Record Number	Policy Number (Group)	Doctors Name and Phone Number

**If for any reason my child or I are injured I give Sacramento State Aquatic Center personnel permission to seek treatment for my personal well-being. I have signed this document of my own free will. I do hereby authorize the performance of medical examinations and necessary treatments (including test, x-rays, drugs, etc...) as may be deemed advisable or necessary by the physician in attendance. This consent shall be in effect for the time my child or I participate in a Aquatic Center W.E.T. program. If an emergency arises requiring a major surgical procedure, the program director will attempt to reach me or a contact from the provided emergency contact list and to be guided for my wishes: but if I cannot be reached, I authorize the attending physician to act as medical judgment may dictate.**

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date of consent: \_\_\_\_\_ Witnessed by: \_\_\_\_\_