ST. MARY'S HIGH SCHOOL
FIELD TRIP PERMISSION SLIP

Student Name _____ **Grade** _____
Date(s) of Field Trip: _____
Purpose of Field Trip: _____
Destination: _____
Method of Transportation:_____
Charter Company: _____
Teacher/Advisor/Chaperone: _____

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 above and initialed by me. I hereby release and save harmless, and agree to defend Saint Mary's High School and indemnify Saint Mary's High School, and any and all of their employees, agents or successors from any and all liability for any and all harm arising to my child or any harm occasioned by my child as a result of my child's participation in the field trip, regardless of any act, omission or negligence on the part of St. Mary's High School, its employees, agents or successors

Permission is given for the student named above: (Please initial appropriate space)
_____to be a passenger when adult will be driving _____to drive his/her own car
_____to travel by public or chartered transportation

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 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 Code)

NECESSARY MEDICAL INFORMATION:

1. Full name of child: _____ 1a. Date of birth: _____
2. In case of accident call: _____ 2a. Home telephone: _____
3. Home address _____ 3a. Work telephone _____
4. Alternate person to call: _____ 4a. Telephone: _____
5. Physician's full name: _____ 5a. Telephone: _____
6. Family Insurance Policy: _____ 6a. Policy number: _____
7. Describe any allergies (drug, food, insect bites, etc) or limitations on physical activities:
   Drug allergies: _____
   Food allergies: _____
   Other allergies: _____
   Physical limitations: _____