SARATOGA SPRINGS EIGHTH GRADE OUTING
COMPLETE BOTH SIDES OF THIS FORM & RETURN TO THE SCHOOL OFFICE
BY FRIDAY, MAY 24, 2019

Student Name ___________________________. Student ID# ______________, has my permission to attend the 8th Grade Saratoga Springs trip on Friday, May 31, 2019 from 9:30am - 2:35pm. Transportation will be by District school buses. Parents who have children that may require special services or accommodations in order to participate, please note requirements here ________________________________.

Lunch will be provided. Please note your student’s special dietary or medical needs on the reverse side.

I understand that all students going on this trip will conduct themselves properly, be responsible to the driver, to teachers, and adult sponsors. It is further understood that students will go and return from the event in the transportation provided.

Hold Harmless Statement. As required by Ed Code Section 35330, I hereby waive all claims, if any, I may ever have against the SANTA CLARA UNIFIED SCHOOL DISTRICT and the STATE OF CALIFORNIA for injury, accident, illness or death occurring during or by reason of my participation in a field trip to Saratoga Springs taking place on Friday, May 31, 2019 from 9:30am to 2:35pm.

I, the undersigned have read the participation criteria and Hold Harmless Statement, and authorize my son/daughter, _______________________, to participate in the 8th Grade Saratoga Springs Trip on Friday, May 31, 2019.

Date Signed ______________________    Signature of Parent or Guardian _______________________    Print Name _______________________

The State does not provide adequate funds to pay for this activity, which costs approximately $28 per student. Our PTSA and ASB fund raising are paying for most of this field trip. A contribution in any amount to help fund the 8th grade field trip to Saratoga Springs is appreciated. All eligible students are allowed to participate.

I wish to contribute $____  □ Cash or □ Check # _____ to support the 8th Grade Saratoga Springs Outing
Please write checks payable to Peterson Middle School. Thank you for your support!

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For School Use: Received_________________ by_______  Donation Paid by □ Cash  □ Check # ___________
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Brad Syth, Principal ~ Krista Keneman, Vice Principal ~ Andy Masur, Vice Principal
bsyth@scusd.net  kkeneman@scusd.net  amasur@scusd.net
An Equal Opportunity Employer – with Non-Discriminatory Programs and Activities
SANTA CLARA UNIFIED SCHOOL DISTRICT
AUTHORIZATION TO TREAT MINOR
CIVIL CODE SECTION 25.8

I authorize school personnel to transport my child to a hospital or medical facility and further authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care deemed necessary by the licensed physician/surgeon/dentist.

Signature __________________________________________________________________________ Date ____________
(Parent/Guardian)

Child’s Name ___________________________ Birthdate _______ Peterson Middle School, Grade 8
Name of Insurance Company____________________ Policy Number __________ OR
Medi Cal Number __________________________
Date of last DPT / TD / Tetanus __________________________
Allergies (food, medicine, insect) __________________________

List any medical conditions and/or other pertinent behaviors/information unique to your child: (i.e. faints easily, frequent nose bleeds, sleep walker, etc.): __________________________

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Authorization for Medication

Name ___________________________ Peterson Middle School, Grade 8

I authorize school personnel to administer medication to my child at _____ AM _____ PM
According to instruction from his/her physician it is my responsibility to send the medication in the original pharmacy container including the child’s name and doctor’s instructions.

Date ___________________________ Signature ________________________________________________
(Parent/Guardian)

To be completed by physician:
Diagnosis ______________________________________________
Medication and instructions ______________________________________________
Medication requested for (length of time) __________________________
Comments: ______________________________________________
Date ___________________________ Signature ________________________________________________
(Physician)