ORLAND UNIFIED SCHOOL DISTRICT
Orland, CA 95963

PARENT PERMISSION FOR SCHOOL-SPONSORED ACTIVITY AND CONSENT TO MEDICAL TREATMENT
(PLEASE COMPLETE BOTH TOP AND BOTTOM SECTIONS OF THIS FORM)

School _____

Name of Student: _____ has the opportunity to participate in a school activity away from school premises. If you approve of the following arrangements, please sign at the bottom of this section and return the form to the faculty sponsor.

Nature of Activity: _____

Destination: _____ Date: _____

Time of Departure: _____ Date/Time of Return: _____

Means of Transportation: (sponsor please check)

- ☐ District-owned Bus
- ☐ Commercial (name of company) _____
- ☐ Other (specify) _____

I understand the nature of the school activity in which my son/'daughter will be participating and that he/she is expected to abide by all school regulations during the course of the activity.

I understand that, pursuant to Education code 44808, the district is liable or responsible for the conduct and safety of my son/daughter only while he/she is, or should be, under the immediate and direct supervision of an employee of the district.

I hereby give my permission for him/her to participate in the activity described above.

I further agree that, in the event of an accident, illness, or any other circumstance requiring medical treatment, such treatment may be procured for my son/daughter without financial obligation to the district.

Date: _____ Signature of Parent / Guardian: _____

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW: _____

EMERGENCY TELEPHONE NUMBERS: _____

…….THIS FORM SHOULD BE KEPT BY THE CHAPERON DURING THE ACTIVITY……..….

AUTHORIZATION TO TREAT A MINOR

I (We), the undersigned parent(s) or legal guardian(s) of _____, a minor, do hereby authorize and consent to any X-ray, examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute care general hospital holding a current license to operate a hospital from the State of California (Oregon/Nevada) Department of Public Health. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to provisions of Section 25.8 of the civil code of California.

Date: _____ Signature: _____

Allergies to Drugs or Foods _____

Date of Last Tetanus Toxoid Booster _____