





**ETIWANDA SCHOOL DISTRICT  
PARENT CONSENT FOR CHILD'S VOLUNTARY FIELD TRIP PARTICIPATION,  
RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT (Page 2 of 2)**

As a parent/guardian of \_\_\_\_\_, I understand that the Etiwanda School District does not provide medical insurance for student injuries but does make voluntary student insurance available. I have received the information on this program.

I will enroll my child in the voluntary student insurance program by contacting Myers-Stevens & Toohey & Co. Inc. at (800) 827-4695.  I will not enroll my child in the voluntary student insurance program.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**STUDENT HEALTH HISTORY FOR FIELD TRIP PARTICIPATION**

Student's Name \_\_\_\_\_ **DOB** \_\_\_\_\_  
 Last First Middle

**Please circle Yes or No. If Yes, please list and include date(s).**

1. Has your child been exposed to a virus or communicable disease within the past 21 days? Yes No \_\_\_\_\_
2. Does your child have any of the following health problems?
 

a. Chronic or recurring illness	Yes	No	_____	g. Hernia (rupture)	Yes	No	_____
b. Recent broken bones	Yes	No	_____	h. Seizures (Epilepsy)	Yes	No	_____
c. Asthma	Yes	No	_____	i. Diabetes	Yes	No	_____
d. Heart disease	Yes	No	_____	j. Operations	Yes	No	_____
e. Hay fever	Yes	No	_____	k. Serious injuries	Yes	No	_____
f. Fainting spells	Yes	No	_____	l. Other	Yes	No	_____
3. Date of most recent **Tetanus** shot \_\_\_\_\_
4. Does your child have any drug or other allergies? (Insect bites or stings, penicillin, plants, foods, etc.) Yes No \_\_\_\_\_

5. Does your child take any medications? Yes No \_\_\_\_\_ If yes, please list type of medication, reason, dosage, frequency, name of prescribing physician \_\_\_\_\_

6. If you have any concerns regarding your child's physical ability to participate in this activity, it is advisable for your child to have a physical examination.

7. If your child takes any medication that must be administered during the field trip, you must have on file a Parental Consent for Administration of Medication form, as required by district policy and state law. Along with the form, an adult must provide the medication and the physician's specific directions concerning administration and dosage, emergency contact information for the prescribing physician, and any other medical instructions. If you need this form, please contact the school office.

Please initial indicating you have read the above items (1-7) regarding Student Health History for field trip participation. \_\_\_\_\_

**FIELD TRIP RELEASE OF LIABILITY AND CONSENT TO EMERGENCY MEDICAL TREATMENT**

The above health history is correct so far as I know, and I consent and grant my permission for my son/daughter/ward to engage in all described activities. Except as noted by me, my child is physically fit to participate.

I (we) the undersigned parent, parents, or legal guardian of \_\_\_\_\_, a minor, do hereby consent that he/she be permitted to attend (event) \_\_\_\_\_ on (date) \_\_\_\_\_ and should the need arise, do hereby authorize and consent to any x-ray, examination, anesthetic, medical or surgical diagnosis and treatment rendered under the general or special supervision of any member of the medical staff or emergency room staff under the provisions of the Medical Practice Act or dentist licensed under the provisions of the Dental Practice Act or the staff of any acute general hospital licensed by the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given to provide authority and power to render any care, which the medical provider in the exercise of his/her best judgment may deem advisable. It is understood that an effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached. I will not hold liable the **Etiwanda School District**, its officers, or employees for medical aid rendered and will reimburse the **Etiwanda School District** for all medical or other expense incurred in the care of my son/daughter/ward. This Authorization is given pursuant to California Family Code section 6910 and remains effective only for the event and date listed above.

In order that my son/daughter/ward may receive the necessary medical treatment in the event of an injury or illness, I hereby hold the **Etiwanda School District** and its representatives harmless in the exercise of this authority.

*Please note: Donations to cover the cost of the field trip and transportation are voluntary and no student will be denied participation in field trip if donation is not made.*

\_\_\_\_\_ **Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_