



LAKE ELSINORE UNIFIED SCHOOL DISTRICT
VOLUNTARY EXCURSION/FIELD TRIP NOTICE/PERMISSION

E 6153(b)

Please print student name _____ Date of Birth _____ School _____

has my permission to participate in the following voluntary activity/field trip:

Departure Date & Time: _____ Return Date & Time: _____

- I understand that the law states in California Education Code Section 35330, that the Lake Elsinore Unified School District, its officers, agents and employees are held harmless from liability or claims which may arise out of or in connection with my child's participation in this activity.
- In the event of illness or injury, 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 of the hospital or facility furnishing medical or dental services.
- Health Insurance company: _____ Policy #: _____
- I fully understand that participants are to abide by all rules and regulations governing conduct during the trip. Any violation of these rules and regulations may result in being sent home at the expense of the parent/guardian.
- I understand that all field trips begin and end at the school.
- Transportation will be provided by:
 ___ District Bus ___ District Chartered Bus ___ District Van ___ Parent
 Other: Please describe _____
- **IMPORTANT** Note to Parent/Guardian: (1) All medications, excepting those which must be kept on the student's person for emergency use (EpiPen/Inhaler) must be kept and distributed by the staff; I understand that it is my responsibility to provide all medications and the proper documentation for each medication. (2) If any medications are to be taken by student, a medication authorization **MUST** be provided for each medication including over the counter medication. All medication will be provided by the parent in the original container with student name, medication name, dosage schedule and route, physician's name and date of expiration of prescription.
 Please List medications here: _____ (3) If your child has a special medical problem, please attach a description of that problem.
Note: All student health information will be kept confidential per FERPA guidelines.

Parent/Guardian Signature _____ Date: _____

Address _____ Telephone _____

This waiver is required for participation in athletics