FORM APPENDIX 7903.11A
Parental and Medical Authorization for Minor/Student Participation in District Approved Off-Campus Activity

_____, whose date of birth is _____, has my permission to participate on _____
(Student's Full Name) (Child's Date of Birth) (Date of Event)

in the _____ activity and will travel by _____.
(Off-Campus Activity Description) (Bus, Private Vehicle, Own Transportation)

As stated in the California Education Code Section 35330, I understand that I hold the Anaheim Union High School District, its officers, agents and employees harmless from any and all liability or claims, which may arise out of or in connection with my child's participation in the activity.

I fully understand that the Anaheim Union High School District does not purchase or have, medical/dental/hospitalization insurance to cover injury or loss of life of pupils, or to indemnify parents/guardians for expenses in connection herewith, and that such insurance, if desired, must be purchased by the parent/guardian.

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 that individual being sent home at the expense of his/her parent/guardian.

Any student who needs to take medication while on an off-campus activity must attached Form Appendix 7903.11B, Parent Request for the Administration of Medication Prescription and Non-Prescription. Contact the Health Office and arrange, prior to the trip, for their medication, along with a copy of the permission form to be sent on the off-campus activity.

Medication (check one):
_____ My child takes no medication(s).
_____ My child will be taking prescription or non-prescription medication while on the off-campus activity. Form Appendix 7903.11B is attached.
_____ A description of any medical issue is attached.

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 and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

In the event I am not available in an emergency, please notify:

Contact Name: _____ Child's Doctor: _____

Phone Number: _____ Doctor's. Phone Number: _____

Parent/Guardian Signature: _____ Medical Insurance Carrier: _____

Phone Number: _____ Policy Number: _____