

**BRITTAN SCHOOL DISTRICT**

**Parental Permission for School Related Field Trips and Activities**

I hereby agree that \_\_\_\_\_ has my permission to participate in the: \_\_\_\_\_ to be held at \_\_\_\_\_ on \_\_\_\_\_.

Time of Departure: \_\_\_\_\_ Time of Return: \_\_\_\_\_

This activity for the students will be under the supervision of: \_\_\_\_\_

Transportation will be provided by:

- District Bus
- Private Car
- Walking
- Commercial

This vehicle will be driven by:

- Licensed School Bus Driver
- District Employee
- Parent

**Bus Rules**

The following rules have been established in order to insure the safety of all students who ride the bus:

- Students are required to obey the bus driver at all times.
- Remain seated, facing front, when the bus is in motion.
- Talk quietly, no unnecessary noise or profanity.
- Do not talk to the driver unless it is necessary.
- Keep head and arms inside the bus.
- Do not litter the inside of the bus.
- NO EATING or DRINKING ALLOWED on the BUS at any time.
- Do not throw anything outside the window.
- Be quiet when the bus is crossing railroad tracks or backing up.

**Any violations of the above rules will be brought to the attention of the Vice-Principal.**

I further agree that in case of medical emergency, illness or injury, the supervisor has my express permission to take the above-named student to a doctor or medical facility to receive emergency treatment pursuant to the following authorization:

I, the undersigned parent/guardian of \_\_\_\_\_ a minor, do hereby authorize the faculty members of the Brittan School District supervising the activity herein described, as my agent to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor under general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California

**IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW:**

My child has the following medical condition and/or allergies: \_\_\_\_\_

\_\_\_\_\_

Family Doctor's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency contact name and number: 1. \_\_\_\_\_

2. \_\_\_\_\_

Signed: \_\_\_\_\_  
Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_