

The Pines Christian School

Trip Permission Slip- 2010

25200 S. Western Avenue, Harbor City, California 90710 Phone (310) 325-1213

We are in accord with the purposes of and procedures governing the following trip/trips. We hereby grant permission for our son/daughter to participate in the following:

All Summer Trips from June 2nd - August 27th

We understand that adequate and appropriate supervision will be provided. We recognize, however, that unanticipated situations and problems can arise on any trip, school-sponsored or otherwise, which situations or problems are not reasonably within the control of the supervising teacher(s) or staff (including volunteers). We further agree to release and hold harmless The Pines Christian School, their agents, officers, employees, and volunteers, from any and all liability, claims, suits, demands, judgments, costs, interest and expense (including attorneys' fees and costs) arising from such activities, including any accident or injury to the student and the costs of medical services. In the event of an injury requiring medical attention, I hereby grant permission to the supervising teacher(s) or staff (including volunteers) to attend to my son/daughter. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the supervising teacher(s) or staff (including volunteers) to take my child to the physician, dentist, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located. In the event that a student must return to school independently for reasons of health, accident, and failure to conform to rules established by the teacher in charge, etc., we agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses.

Student Name _____

Parent or Guardian signature _____ Date _____

Home Phone _____ Work Phone _____ CellPhone _____

Please check below IF your child has sensitivity to:

Bee Sting Nuts Dairy Latex Other _____

Required medications: _____

Please check below IF your child has:

Asthma Diabetes Kidney Injuries Seizure Disorder Heart Condition Other _____

Required medications: _____

Other medications: _____

If the student requires medication, I understand that I am obligated to ensure that the medication and the Medication Authorization Forms are on record in the Office.

Comments

