St. Bernard's Catholic Preschool

160 West Beverly Place * Tracy, California * (209)835-8019 * License # 393620018/393620019

Walking Field Trip Permission Form 2024-2025

Child's Name: _____ Class:_____

WALKING FIELD TRIPS WILL TAKE PLACE THROUGHOUT THE SCHOOL YEAR. **THIS PERMISSION SLIP GRANTS PERMISSION TO TAKE YOUR CHILD FOR A WALK AROUND THE SCHOOL GROUNDS.**

The purpose of the walking field trip would be to attend Mass, visit classrooms in the school, attend activities in Father Fleming Hall, or just go on an adventure exploring nature.

I, undersigned parent or legal guardian of the above named student, give my permission for his/her participation in the St. Bernard's Catholic Preschool field trip. I hereby release and save harmless the school and any and all of its employees from any and all harm arising to my child and for any loss of property as a result of this trip.
Permission is given by: _____

Medical Permission Form

I, the undersigned parent or legal guardian of _____, a minor, do hereby appoint teacher/advisor and/or chaperone as agent(s) for the undersigned for the purpose of authorizing and signing any consents for any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medial Practice Act on the medical staff of the nearest Emergency 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 physical in the exercise of his/her best judgment may deem advisable.

The authorization is given pursuant to the provisions of Section 25.8 of California Civil Code and shall remain from August 2017 to June 2018 unless sooner revoked in writing to said agent(s).

Parent/Legal Guardian Signature

_____ _____

Parent or Legal Guardian Signature Date

Necessary Medical Information

Full name of child:_____ Date of Birth:_____
In case of accident, call _____ Home Phone:_____
Home Address:_____ Work Phone:_____
Alternate Person to call:_____ Phone:_____
Physician's Full Name:_____ Phone:_____
Family Insurance Policy:_____ Policy Number:_____
Describe in full any allergies (drug, food, insect bites, etc.) or limitations on physical activity:

Drug allergies:_____
Food allergies:_____
Other allergies:_____
Physical limitation:_____
Current Medications:_____