MONTEBELLO UNIFIED SCHOOL DISTRICT

VOLUNTEER OR EMPLOYEE PARTICIPATION IN
☐ DISTRICT ☐ NON-DISTRICT SPONSORED FIELD TRIP

ASSUMPTION OF RISK, EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Volunteer or Employee Chaperone Field Trip Form

Name of Volunteer or Employee:_____

Destination/Nature of Activity:_____
(Please be specific, e.g., attend workshop at UC Berkeley)

Purpose of Your Attendance: (Chaperone, etc.) _____

FROM: Date _____ Time:_____ TO: Date:_____ Time:_____

Method of Transportation: ☐ School Bus ☐ Walking ☐ Other: _____

In the event of emergency illness or injury, I do hereby consent to whatever X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. I further understand that all medical expenses are fully my responsibility.

All Volunteers shall provide evidence that they are free from active tuberculosis at least once every four years pursuant to Education Code 49406. Volunteer/Chaperones shall undergo fingerprinting pursuant to Education Code 45125. Fingerprinting to be done with district forms, at district expense. (Employees were fingerprinted when hired. TB must be up to date at time of trip.)

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip. See MUSD Administrative Regs. 5131 & 5131.1.

As provided for in California Education Code Section 35330, I agree to waive all claims against the Montebello Unified School District (District) and hold-harmless the District, its officers, agents and employees, from any and all liability or claims, which may arise out of or in connection with my participation in this activity. This waiver shall not apply to any occurrences that may arise solely out of the negligence of the District, its employees or agents.

_____ _____
Signature Date

_____ Cell Phone ( ) _____
Address

Home Phone ( ) _____

_____
City State Zip Code Work Phone ( ) _____

Health Insurance Company:_____ Policy Number:_____
(e.g., Kaiser, Blue Cross) (or member number)

☐ Yes Special Medical Concerns: _____
(e.g., Diabetic, Asthma) Attach sheet if necessary.

☐ No Medical Concerns

In the event of illness or accident, please notify:

Name:_____ Relationship:_____

_____ Cell Phone ( ) _____
Address

Home Phone ( ) _____

_____
City State Zip Code Work Phone ( ) _____

SCHOOLSITE OFFICE USE:
TB Clearance received from Volunteer
Fingerprint Clearance received from Classified Human Resources *(Attach copy of clearance notice to the Principal Checklist Form FT-1)*

RETURN TO SITE ADMINISTRATION OFFICE