



Annunciation Preschool

440 West Rose Street
Stockton, CA 95203
(209) 465-2961

Walking Field Trip Permission Form

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. WALKING WILL ONLY BE WITHIN ONE BLOCK OF THE SCHOOL.

The purpose of the walking field trip would be to gather leaves, rocks, bugs or just go on an adventure exploring nature.

I, the undersigned parent or legal guardian of the above named student, give my permission for his/her participation in the Annunciation Preschool field trip. I hereby release and save harmless the school and any and all of it's employees from any and all harm arising to my child and for any loss of property as a result of this trip.

Permission is give 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 Medical 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 effective from 2018 to 2019 unless sooner revoked in writing to said agent(s).

Parent/Legal Guardian Signature

Parent or Legal Guardian Signature

Date

Necessary Medical Information

- 1. Full Name of Child: _____
- 3. In Case of Accident, Call _____
- 5. Home Address: _____
- 7. Alternate Person to Call: _____
- 9. Physician's Full Name: _____
- 11. Family Insurance Policy: _____

- 2. Date of Birth: _____
- 4. Home Phone: _____
- 6. Work Phone: _____
- 8. Phone: _____
- 10. Phone: _____
- 12. Policy Number: _____

- 13. 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: _____