



# Immaculate Conception Academy

3625 – 24<sup>th</sup> Street · San Francisco, CA. · 94110-3607 · (415) 824-2052 · Fax (415) 821-4677

## FIELD TRIP PERMISSION FORM

ACTIVITY **2009 VOLLEYBALL TEAM CONTESTS/EVENTS**

Place various City, State various

Date(s) See schedule Means of Transportation Charter bus

Time of Departure from School TBD Time of Return from School TBD

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
(Street, City, Zip)

Parent/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
(Street, City, Zip)

Person(s) Other Than Parent to Notify in Case of Emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

I/We, the parent(s)/guardian of \_\_\_\_\_ request that Immaculate Conception Academy allow my/our daughter to participate in the above named activity. In consideration, I/We, hereby release and save harmless Immaculate Conception Academy and any and all its employees from any and all liability for any and all harm arising to my/our daughter as a result of this trip. I/We agree to direct my/our daughter to cooperate and conform with the directions and instruction so of the school personnel responsible for the activity.

I/We agree to the extent permitted by law, that in the event my/our daughter is injured as a result of her participation in the above named activity, including but not limited to transportation to and from the activity, whether or not it was caused by the negligence (active or passive) of the school or any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

I/We am/are not aware of any medical condition of my/our daughter which would render it inappropriate for her to participate in any such activity. I/We, hereby, give permission to physician selected by school personnel then present to render medical treatment deemed necessary and appropriate by the physician.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Other Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

*While being sensitive to single parent situations and possible embarrassment to the daughter, signatures of both parents should be obtained when possible.*