ARCADIA UNIFIED SCHOOL DISTRICT

Transportation Permission Card

Please Print

Student I.D. #_____

Name of Student *Grade Level* *Address* *Home Phone*

Mother *Business Phone*

Father *Business Phone*

Neighbor or Local Friend *Phone*

Family Physician *Phone*

IMPORTANT: Please Note!
No insurance is provided for this event by the Arcadia Unified School District, or the Arcadia High School Associated Student Body.

Parent signature on this card is the teacher's authorization to call any reference listed in case of emergency; and also authorizes your son/daughter to be transported to an event and return to school in order to participate in a school program or activity by either school or commercial bus. Special circumstances may require transportation by private automobile driven by teachers or a parent.

Parent's/Guardian's Signature **Date**

Rev.1/07 10-00033

HOSPITAL CONSENT FORM

Child's Date of Birth: _____

Date: _____

We, the undersigned, parent(s)/guardian(s) of _____, a minor, do hereby consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of _____, M.D., at telephone no. _____, or the Emergency Room Physician, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage said physician(s) to exercise his/her best judgment as to requirements of such diagnosis or treatment.

This consent shall remain effective until revoked in writing, or until the end of the current school year (June, 20_____), or until child's 18th birthday.

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California.

Father's Signature: _____ Date

Mother's Signature: _____ Date
OR
Legal Guardian's Signature: _____ Date

Neighbor/Local Friend: _____ Date

Witness: _____

Witness: _____

Witness: _____

Neighbor/Friend's Phone: _____

Home Address: _____
Home Phone: _____
Business/Cell Phone: _____
Known Allergies: _____

Name of Insurance Company: _____

Certificate # _____
Group # _____
Phone # _____

Known Medical Problems: _____