Fit For Bloomsday Permission Slip 2019

_____ _____/____ _____
Name of Student (Please Print) Teacher/Grade Name of Parent/Guardian (Please Print)

I, the undersigned parent or guardian of the above named student, give my permission for my student to participate in the instructional activity described as follows:
Date of activity**: April 16, 18, 23, 25, 30 & May 2 Tuesdays & Thursdays**
***Time*: 3:15 - 4:15 PM**
Destination and activities: Chester Playground, Gym - walking & jogging Teacher/Advisor: Mr. Hubble

Emergency Medical Information and Authorization

mhubble@cvsd.org

Father/Guardian/Custodian Name_____ Home Phone#_____ Work#_____
Cell#_____
Mother/Guardian/Custodian Name_____ Home Phone#_____ Work#_____
Cell#_____
Doctor's Name Phone#_____
Dentist's Name Phone#_____
Name of person to notify if parent/guardian/custodian can't be reached_____
Phone#_____
Permission to treat if necessary: ☐ Yes ☐ No
Permission to transport to nearest medical facility if unable to reach parent/guardian: ☐ Yes ☐ No

To: Emergency Medical Personnel:
I, the undersigned parent/guardian/custodian of
_____
Student's name
a minor, authorize accompanying school personnel to consent in any emergency situation to any x-ray examination, laboratory test, anesthetic, medical or surgical procedure or hospital care required on the above minor while in their custody, and for which I am unable to be reached to provide consent. Such care must be recommended by and performed under the supervision of a physician licensed to practice medicine in the United States. I understand that if transportation by ambulance is necessary, I must assume the financial responsibility. My student may be released to accompanying school personnel following completion of treatment and in my absence.

Please list any allergies your student may have, any medications being taken, special health problems we should know to assist in your student's safety. (ie Heart condition, hemophilia, diabetes, asthma, other)
Allergies:_____
Medications:_____
Other considerations:_____
Current physician and parent permission forms for **Administration of Medication at School** must be obtained if medication is not routinely being given at school.
I understand the district does not provide medical insurance for my student for purposes of this trip, and I am solely responsible for providing insurance and for payment of any medical treatment expenses for my student that are not covered by insurance.
I have read the foregoing information, verify its accuracy, and agree to the statements made above

Sign:_____ Date:_____
Parent/Guardian Signature **Date signed**

Chester Elementary Central Valley School District
Mr. Hubble
H&F Teacher/Fit for Bloomsday Coach
Chester Elementary
mhubble@cvsd.org 558-3194