Sacred Heart Catholic Preschool
505 M Street
Patterson, Ca 95363
209.892.5525

Student Name_____

Date(s) of field trip_____**8/30/26-5/30/27**_____
Purpose of field trip_____**Enrichment**_____
Destination_____**Main School**_____
Method of transportation__**Walking**_____
I, the undersigned, parent or legal guardian of the above-named student, request the he/she be allowed to participate in, and give my permission for his/her participation, those school activities described above. I hereby release and save harmless the school and any and of its employees from any and all liability for any and all harm arising to my child and for any loss of property as a result of those activities.

Permission is given for the student named above:
_____to travel by chartered or public transportation
____**X**____walking to destination

MEDICAL PERMISSION FORM
I, the undersigned, parent or legal guardian of _____, a minor, do hereby appoint Teacher/Director/Chaperone as agent(s) for the undersigned for the purpose of authorizing and signing any consents for any x-ray examination, anesthetic, medial 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 medial staff of 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 agent(s) to give specific consent to any and such diagnosis, treatment or hospital care which any physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the California civil Code and shall remain effective from **8/30/26** to **5/30/27** unless sooner revoked in writing to said agent (s).

_____
Parent/legal guardian signature date

_____
Address city zip

Medical information: See Red Binder