AGREEMENT FOR VOLUNTARY ACTIVITY PARTICIPATION
AND AUTHORIZATION FOR MEDICAL CARE

To the Principal of Sierra Academy of Expeditionary Learning (student name)_____ has my permission to participate in the 11th Expedition Kick-Off Event at the South Yuba Club Friday, January 24th, 2020

To be held at: South Yuba Club 130 West Berryhill Drive, Grass Valley

Teachers: Mr. Bird, Mr. Young, Ms. Hooper

Method of Transportation: Students will be driven to and from by SAEL approved drivers.

SPECIFIC ACTIVITIES:

(1) Students will engage in vigorous stationary bike riding

PARENTS, PLEASE NOTE: Section 35330 of the California Education Code states in part: "All persons making the field trip shall be deemed to have waived all claims against the district, charter school, or the State of California for injury, accident, illness, or death occurring during or by reason of the field trip or excursion." Failure of student to comply with rules may result in student being sent home at parent/guardian's expense. Field trips are voluntary and a privilege; **student may remain in school at parent/ guardian's request**.

ASSUMPTION OF RISK: By signature hereon, parent/guardian waives liability against the school and acknowledges that the trip and its activity(s) may expose the student to potential harm including injury or death.

X_____
Authorized Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian Date

☐ Check here if child **may not** participate in Activity number: (1) [Please provide details and an explanation on the back of this sheet]

AUTHORIZATION FOR MEDICAL CARE

If it becomes necessary for my child to have medical care while participating in this trip, I hereby give school personnel permission to use their judgment in obtaining medical care for the child, and I give permission to the physician selected by school personnel to render medical care deemed necessary and appropriate by the physician. I understand that the school carries student accidental injury insurance in an amount limited to $50,000 (applies excess of family health insurance if applicable.)

X_____
Authorized Signature of Parent or Guardian

Student Name: _____

Home Address: _____

Parent/Guardian Home Phone No.: _____

Parent/Guardian Work Phone No.: _____

Emergency Contact Phone No.: _____

_____
Parent or Guardian's Name (please print)

_____ Date: _____
Authorized Signature of Parent or Guardian

☐ PLEASE CHECK HERE IF INSTRUCTIONS FOR SPECIAL MEDICAL TREATMENT AND/OR OVER-THE-COUNTER MEDICATION FOR THE STUDENT ARE ON FILE IN THE SCHOOL.