Student ID#: ____________

PLEASANTON UNIFIED SCHOOL DISTRICT
STUDENT FIELD TRIP AUTHORIZATION

EMERGENCY MEDICAL INFORMATION

Name of Child: ______________________________ Date: ______________

Name of Parent/Guardian: ______________________________ Home Phone: ______________

Work Phone #1: ______________________ Work Phone #2: ______________________

Name of Physician: ______________________________ Physician Phone: ______________

Name of Dentist: ______________________________ Dentist Phone: ______________

Name of Medical Insurance Company: ____

Group/Coverage Number: ______________________

Allergic to the following: ____

Taking the following medication(s): ____

Special Instructions:

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I hereby give my consent to the Pleasanton Unified School District, to whose care my child has been entrusted, the authorization for any emergency medical treatment, including any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care needed to be rendered on the advice of any physician, surgeon, medical practitioner, or under the provisions of the Dental Practice Act.

______________________________________ ______________________________

Signature of Parent/Guardian Date