San José State University MESA Center
College of Science, DH-241
One Washington Square
San José, CA 95192-0099
Phone: (408) 924-3798, Fax: (408) 924-4026

School: _____ Grade: _____

FIELD TRIP PARENT / LEGAL GUARDIAN CONSENT FORM

AND

EMERGENCY MEDICAL TREATMENT

I request that *(Student Name)* _____ be allowed to attend the following MESA fieldtrip to: **MESA Day**

at **San Jose State University** on _____via _____

Pick up location / time: **School Site**

Drop off location / time: **From SJSU to School Site**

In the event the student, who is a minor, becomes ill or sustains an injury while in the care or under the supervision of the directors or leaders of the MESA program, any of its officers or leaders are given permission to administer First Aid for his / her relief. If it is not practical to return him / her to us or to receive our instructions for his / her care, I (your name) _____, parent / legal guardian, do hereby authorize MESA as agents for the undersigned to consent for any x-ray examination, anesthetic medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by and rendered under the Medicine Practice Act on the medical staff of a licensed physician or at the said hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This authorization is given pursuant to Section 25.8 of the Civil Code of California and remains effective only for the event and dates listed above. Parents / Legal Guardians will be contacted immediately (if possible), should any illness or accident occur to the student on the trip.

I will not hold liable the MESA organization, its officers or leaders, or the school district for medical aid rendered and will reimburse the MESA organization and / or its officers and leaders for medical or other expenses incurred in the care of the student.

_____

Signature of Parent / Legal Guardian Date

Parent / Legal Guardian Phone Number(s):

_____

Home Phone # Work Phone # Emergency Phone #

Family Doctor Information:

_____

Name Address Phone #

Date of last tetanus shot: _____ Allergic to: _____