

Los Angeles Community College District

EXCURSION/FIELD TRIP FORM

All participants complete Sections A and B:

- A. WAIVER
- B. MEDICAL AUTHORIZATION

Also complete Section(s) C and/or D and/or E, if applicable:

- C. NON-CLUB MEMBER
- D. A PARTICIPANT PROVIDING HIS/HER OWN TRANSPORTATION
- D. MINOR

A. WAIVER

Activity: _____

Campus/Class/Group: _____

Supervising Academic Employee: _____

Departure Date & Time: _____ Return Date & Time: _____

As stated in California Code of Regulations, Subchapter 5, Section 55450, I understand and agree that I shall hold the Los Angeles Community College District, its Board of Trustees, officers, agents, representatives, employees, and permissive users of District vehicles harmless from any and all liability, claims, causes of action, and demands related to, arising out of or in connection with my participation in this activity, including injuries, accident, illness or death.

If my participation in this activity results in any liability, claims, causes of action, or demands against the Los Angeles Community College District, its Board of Trustees, officers, agents, representatives, employees, and permissive users of District vehicles, I agree to defend and indemnify the District, its Board of Trustees, officers, agents, representatives, employees, and permissive users of District vehicles in such an action.

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip. Any violation of these rules and regulations may result in my being sent home at my own expense.

My signature on this document acknowledges that I have read and understand the above provisions and agree to abide by these terms.

Participant's Printed Name

Signature of Adult Participant or of
Parent/Guardian on behalf of Minor Participant

Date

Address

Phone Number

B. MEDICAL AUTHORIZATION:

In the event of any illness or injury while participating in the activity listed in Section A, I hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care from a licensed physician, surgeon, and/or dentist as deemed necessary for my safety and welfare. It is understood that the resulting expenses will be my responsibility.

Participant's Printed Name

Signature of Adult Participant or of
Parent/Guardian on behalf of Minor Participant

Date

Participant's Medical Insurance Carrier

Policy Number

Medical Insurance Carrier Address

Medical Insurance Carrier Phone Number

In the event of illness, accident, or other emergencies, please notify:

Name

Address

Phone Number

Medical Condition: Check here if you have a special medical condition and attach a description of that condition to this sheet.

