



**Waiver of Claims and Consent to Treatment**

Division: \_\_\_\_\_ Class: \_\_\_\_\_ Faculty Member: \_\_\_\_\_

Field Trip Destination: \_\_\_\_\_

**Departure:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Depart From: \_\_\_\_\_

**Return:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location of Return: \_\_\_\_\_

Mode of Transportation: \_\_\_\_\_

The undersigned student acknowledges receipt of this form providing notification of the above-described field trip or trips. The undersigned student (check one) will attend \_\_\_\_\_ will not attend \_\_\_\_\_ the field trip or trips and requests that any absences be excused. **(Reason for not attending must be explained \_\_\_\_\_ )**.

The district will provide free transportation to and from the destination. Students who do not use District provided transportation shall not be permitted to participate in field trip activities, shall not receive credit for the field trip and shall not be granted an excused absence from other classes that are missed.

**Waiver of Claims**

I voluntarily apply to go on the identified field trips or excursions and do hereby waive, relinquish and agree not to pursue any claims, actions, or demands against San Joaquin Delta Community College District its trustees, officers, professors, supervisors, its agents or other employees for injury, accident, illness or death which may arise out of, or occur during or by reason of said field trip or excursion. This waiver is intended to apply to myself and any of my heirs, guardians, successors or legal representatives. The undersigned student acknowledges that he or she has received this form, has read and understands it, and agrees to be bound by its terms.

\_\_\_\_\_  
Please Print Student Name Student Signature

Dated: \_\_\_\_\_

**Consent to Treatment**

In case of medical emergency, the undersigned hereby authorizes San Joaquin Delta College person to obtain emergency medical treatment from a physician, emergency care facility, hospital, paramedic unit, or from such other sources as may seem appropriate under the circumstances.

\_\_\_\_\_  
Please Print Student Name Student Signature

Dated: \_\_\_\_\_

\_\_\_\_\_  
Name of Student's Physician Physicians Phone Number

Address of Physician: \_\_\_\_\_

**Parent/Guardian Information:**

If student is under the age of 18 and has not been declared an emancipated minor, this form must be signed by the student's parent or legal guardian.

\_\_\_\_\_  
Please Print Name of Parent/ Legal Guardian Parent/Legal Guardian Signature

Dated: \_\_\_\_\_

Parent Guardian Phone Number: \_\_\_\_\_