

State Center Community College District

FIELD TRIP/EXCURSION FORM

All participants complete Sections A and B:

- A. WAIVER
- B. MEDICAL AUTHORIZATION

If applicable, complete Section(s) C, D, E:

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

A. WAIVER

Activity: _____

Campus/Class/Group: _____

Supervising Faculty/Employee: _____

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

As stated in California code of Regulation, subchapter 5, Section 55450, I understand and agree that I shall hold State Center 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 State Center Community College District, its Board of Trustees, officers, against, 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 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 Parent/Guardian of Minor Participant	Date
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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 medical treatment and/or 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 Parent/Guardian of Minor Participant	Date
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Participant's Medical Insurance Carrier	Medical Insurance Carrier Phone	Policy #
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In the event of illness, accident, or other emergencies, please notify:

Name	Phone	Optional Phone
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