MT. SAN ANTONIO COLLEGE

STAFF Participation in Voluntary Field Trip
Assumption of Risk and Medical Treatment Authorization

Staff Name:		*Department*
Address:		
Home Phone ( )	*Cell Phone* ( )	*E-mail:*
Destination and Description of Activity: UCLA Conference Center, Lake Arrowhead, A.S. Leadership Conference		
Departure Date: Friday, September 21, 2007 – Sunday, September 23, 2007		*Return Date:*
Faculty/Staff/Advisor Name: Dyrell Foster, Student Life Office, x4525	*Department:*	*Telephone #*

Type of Transportation: ☐ I will use transportation provided by Mt. San Antonio College
☐ I will accept responsibility for arranging my own transportation

Health or Special Needs: ☐ I have no special health needs and no medications required
☐ I have special needs, see attached information
*(include allergies, medical conditions and medications currently taking) **
☐ Other: _____

** If you are currently taking medication, please remember to include them with your personal belongings*

In the event of illness or injury, I do hereby consent to all x-ray examinations, anesthetic, medical, surgical, dental diagnosis or treatment, hospital care and emergency transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

As a condition of my participation in this activity, I agree to waive all claims against the District and to indemnify and hold the District, it's officers, agents and employees, harmless from any and all liability or claims, demands, losses, causes of action, suits or judgments of any kind whatsoever that I, my heirs, executors, administrators or assignees may have against the District or that any other person or entity may have against the District because of any death, bodily injury, personal injury, or illness, or because of any loss to property that may arise out of or in any way be connected with the above-described excursion/field trip. This waiver shall not apply to any occurrences that my arise solely out of the negligence of the District, its employees or agents.

I further acknowledge that the District does not provide any type of insurance including liability, collision, comprehensive or medical coverage for students who provide their own transportation or provide transportation for other individuals in connection with an excursion/field trip activity.

_____ _____
Staff Signature *Date*

_____
Staff Name – Please Print

Medical Insurance Carrier (e.g., Blue Cross): _____ *Policy Number:*_____

In the event of an emergency, please contact: _____
Name & Relationship

Home ( )_____ *Work* ( )_____ *Cell* ( ) _____