



**Volunteer Driver (Must be 18 or Older)
Private Vehicle Use Agreement**

Driver's Name: _____ Driver's Cell Phone No.: (____) _____ DOB _____

School Sponsored Field Trip to: _____

Vehicle Make: _____ Model: _____ Year: _____ License No.: _____ Capacity: _____

Driver's Insurance Company: _____ Driver's Auto Policy No.: _____

Insurance Expiration Date: _____

Driver's California Driver's License No.: _____ Expiration Date: (____) _____

Driver's Home Address: _____
Street City Zip

I have attached to this Agreement copies of the following items:

- Department of Motor Vehicle record from the past three years;
- Current registration;
- Valid California Driver's license;
- Automobile policy insurance declaration detailing my insurance coverage and limits (insurance minimums Public Liability/Bodily Injury - \$100,000/\$300,000; Property Damage - \$100,000; Uninsured Motorist \$100,000/\$300,000; Medical \$5,000)

I hereby certify that I have and will maintain automobile liability insurance for the vehicle being used to provide transportation, which covers the driver and all passengers in the automobile, and I have ascertained that my policy will cover myself and all passengers riding in the automobile in connection for the following school activity. I further certify that I have never been convicted of a misdemeanor or felony driving under the influence, had my license suspended within the last three years, or cited with more than one moving violation within the past year; the vehicle that will be used is in proper working order and meets all applicable safety standards; and the vehicle is not designed to carry more than seven passengers plus the driver, for a maximum total of eight persons in the vehicle. I certify that I will enforce that seatbelts are worn by all student passengers. I will advise CHAMPS of any change in the information provided in this Agreement in a timely manner.

I understand that in case of any type of accident, injury, or vehicle damage, CHAMPS' liability insurance policy DOES NOT provide primary or direct insurance on my vehicle. CHAMPS' insurance will take effect only after my personal auto insurance limits are exhausted.

I understand that as a driver for a school sponsored event, I must act in a supervisory manner on behalf of CHAMPS with respect to the student passengers in my vehicles. I further understand that I am not acting as an employee of CHAMPS and will not be compensated in any way for the voluntary services offered in this Agreement.

Driver's Signature: _____ Date: _____

STUDENT PASSENGER WAIVER FORM

CHAMPS
CHARTER HIGH SCHOOL
of the *arts*
multimedia and performing

Please fill in all Information *

Student Name: _____ Cell number: _____

Parent Name: _____ Cell Number: _____

PASSENGER RULES

All State Driving Laws apply to drivers carrying student passengers.

All student passengers must provide CHAMPS with a completed "Student Passenger Waiver Form"

A separate form must be provided for each driver you plan to ride with.

Parent

date

Student

Administrator: _____



CHARTER HIGH SCHOOL of the arts - multimedia and performing

Permission to Participate

General Information

I, _____ (insert parent/guardian's name), give _____

(insert student's full name) my permission to participate in the school trip to _____

on _____ (insert date) beginning at _____ (insert departure time) and returning

at _____ (insert return time).

Supervising Staff(s) include: _____

Chaperone(s) include: _____

Meals:

Student should bring a meal

Student should bring money to purchase a meal

Meal(s) will be provided

No. of meals: _____

Suggested amount: \$ _____

Student's Date of Birth: _____ Student's Grade Level _____

Student's Address: _____

Street City Zip
Student's Cell Phone No.: (_____) _____ Student's Home No.: (_____) _____

Parent/Guardian Home No.: (_____) _____ Parent/Guardian's Work No. : (_____) _____

Parent/Guardian Cell Phone No.: (_____) _____

I agree to direct my student to cooperate and conform to all rules and regulations governing conduct on this trip. Any violation of these rules and regulations may result in the school contacting the parents/guardians and arranging transportation home for the student at the parents/guardian's expense. I fully understand the following:

1. Participation in these activities is voluntary.
2. I may revoke this permission at any time by notifying CHAMPS Charter High School in writing.
3. Revocation is not effective until CHAMPS Charter High School acknowledges receipt.

Method of Transportation

Please check all applicable boxes for this field trip below.

School Bus: If school bus transportation is provided for this trip, I authorize my child to ride the school bus. I understand that there may or may not be seatbelts available on the bus for my student to use. If there are seatbelts available, I have instructed my student to use one.

Private Vehicle: If school bus transportation is not provided for this field trip or a mix of school bus(es) and private vehicles are used for this field trip; I authorize my child to use the following mode of transportation to participate in the event name on this form. Please check all applicable boxes for this field trip below.

- Ride in a private vehicle driven by a non-student parent/guardian. Driver must be 18 years or older and have on file with CHAMPS a completed Volunteer Driver form.
- Ride in a private vehicle driven by a CHAMPS student. Driver must be 18 years or older and have on file with CHAMPS a completed Student Driver form.
- I do not permit student to ride in any private vehicle. I understand that if a school bus is not available for this field trip, my student will not be able to participate.

After School Hours Home Transportation

Once a student has returned to school from a field trip, it is the responsibility of the Parent/Guardian to make sure their child gets back home. **Please check which one applies to your student, if the scheduled return time above is after school hours:**

- I understand that my child will be taking public transportation home.
- I will pick up my child upon returning to CHAMPS. I understand that if I am going to be more than 15 minutes late, I will call the supervising staff member.
- I give permission for _____, student's _____ (insert relationship to student) to pick up my child on my behalf. Driver's Phone No: (____) _____

Medical Authorization

Should it become necessary for my student to have medical treatment while participating in this field trip, I hereby give CHAMPS Charter High School staff permission to use their judgment in obtaining medical service for my child and I hereby give my permission to the physician selected by CHAMPS staff to render medical treatment deemed necessary and appropriate by the physician or hospital. In case of an emergency, I authorize my child to have medical treatment, which may include transportation to the nearest emergency facility. I understand that CHAMPS has no insurance covering such medical or hospital costs incurred by my child and, therefore, any costs incurred for such treatment shall be my sole responsibility. I further understand that no CHAMPS employees, agents or volunteers are licensed to administer medications.

A special note to parents/guardians:

1. Please check here if there are any special instructions regarding medical treatments that are on file with CHAMPS, including the Self Administration of Medicine Forms or Medical Assistance Forms
2. Please attach a list of any medications that your child must take during this field trip and complete and return to CHAMPS the Self Administration of Medicine Forms or Medical Assistance Forms, including the Written Statement of Prescribing Physician, if such forms are not already on file.
3. All prescriptions, except those that must be kept on the student's person for emergency use, must be kept and distributed by CHAMPS staff or chaperone on the field trip.

Student's Medical Insurance Information: (please check one)

- My child is covered by medical insurance: Insurance Carrier _____ Policy No.: _____
 My child is NOT covered by medical insurance.

CHECK HERE IF NO BLOOD TRANSFUSIONS OR BLOOD PRODUCTS ARE TO BE GIVE TO YOUR STUDENT

Student Allergies include (list any food, medicine, or other known allergies): _____

Emergency Contact Information

PRIMARY EMERGENCY CONTACT (Parent/Guardian Information)

Parent/Guardian Name: _____

Relationship to Student: _____ Cell Phone Number: (____) _____

Work Number: (____) _____ Home Number: (____) _____

SECONDARY EMERGENCY CONTACTS

In case of emergency, if I cannot be reached, I authorize CHAMPS to contact or release my child to either of the individuals listed below:

Contact No. One's Name: _____ Relationship to Student: _____

Cell Phone Number: (____) _____ Other Number :(____) _____

Contact No. 2's Name: _____ Relationship to Student: _____

Cell Phone Number: (____) _____ Other Number :(____) _____

Release from Liability, Assumption of Risk and Indemnity Agreement

All participants in the activity described below must read and sign this agreement. If the participant is under 18 years of age, a parent or guardian must read this agreement, agree that the minor may participate in the activity described below and sign the agreement on the minor's behalf. The minor must also read and sign this agreement.

1. RELEASE FROM LIABILITY. For and in consideration of permitting _____ (insert student's name) (the "Participant") to participate in _____ (insert field trip name/description), including but not limited to transportation to and from the location, (the "Trip"), I hereby voluntarily release, discharge, waive and relinquish any and all claims or causes of action, including but not limited to negligence and strict liability, for personal injury, property damage, or wrongful death arising from the Participant's participation in, or activities related to, the Trip against CHAMPS Charter High School of the Arts – Multimedia and Performing, the Governing Board of CHAMPS and/or their officers, agents, employees or volunteers, including chaperones and volunteer drivers, (collectively "CHAMPS"). I also expressly agree to release, discharge, waive and hold harmless CHAMPS from any act or omission of negligence in rendering or failing to render any type of emergency or medical services. In signing this agreement, I fully recognize and understand that if I am injured, die or my property is damaged, I am giving up my rights (as well as the rights of my heirs, executors, administrators or assigns) to make a claim or file a lawsuit against CHAMPS even if they negligently or by some other act or omission cause the injury, death or damage.

2. ASSUMPTION OF RISK, INCLUDING NEGLIGENCE. I hereby acknowledge I have voluntarily chosen to participate in the Trip. I understand that many activities during the Trip may have risks and hazards where injury, death or property damage can occur. I understand there are risks in riding on a school bus or with a volunteer driver, including but not limited to injury, death or property damage as a result of a vehicle accident. I hereby acknowledge that I intend to assume all risks and to exempt, release and relieve CHAMPS from any and all liability, including strict liability, for personal injury, property damage, or wrongful death, including that caused by negligence.

3. INDEMNIFICATION AND HOLD HARMLESS. I, for myself, my heirs, executors, administrators or assigns, agree to hold harmless and indemnify CHAMPS from any and all claims, including any and all defense costs, (which shall include attorney's fees), incurred in connection with the claims for bodily injury, wrongful death or property damage, sustained by me, or in connection with claims for bodily injury, wrongful death or property damage sustained by third parties which may have been caused by me, whether negligent or not, in the course of my participation in the Trip.

4. PARTICIPANT'S RESPONSIBILITIES AND REPRESENTATIONS. I hereby agree to follow all rules, regulations, and instruction of CHAMPS while on the Trip. I also represent that the Participant is physically and mentally capable of participating in the Trip.

5. CALIFORNIA LAW AND VENUE. I agree that this agreement shall be governed by and construed in accordance with California law. In the event any legal action is commenced to enforce or interpret the provisions of this agreement, the venue for any such action shall be in the State of California. The courts or laws of any other state of the United States, United States Federal courts, or the courts of any other nation, shall not have jurisdiction over this agreement and the enforcement of its provisions.

I acknowledge that I have read the foregoing Permission to Participate, including the General Information, Method of Transportation, After School Hours Home Transportation, Medical Authorization, Emergency Contact Information and the Release from Liability, Assumption of Risk and Indemnity Agreement, and I am fully aware of the potential dangers and risks inherent and incidental to participating in the Trip. I am fully aware of the effect of signing this written instrument. I voluntarily sign my name as evidence of my acceptance of all of the above provisions and selections.

Parent/Guardian of Student

Parent/Guardian Signature

Date

MEDICATION PROCEDURE

Student Name: _____

If your student requires any specific medications or treatments such as cough syrup, antacids, topical cream or is on any medication, they must be given to the supervising staff or chaperone and a current and complete Self Administration of Medicine Forms or Medical Assistance Forms, including the Written Statement of Prescribing Physician must be on file with CHAMPS. Students may not self-medicate without having the Self Administration of Medicine Forms, including a Written Statement of Prescribing Physician, on file. All precautions will be taken to protect the student's privacy surrounding medical treatments.

If your student has a chronic condition that requires prompt attention / medication such as diabetic, allergies or convulsions, the supervising staff or chaperone **MUST** have a copy of the current dose of the medication on the trip and a copy of the doctor's instructions. Students with any chronic condition must make the Field Trip Administrator aware of their condition. Please be advised that no CHAMPS employees, agents or volunteers are licensed to administer medications.

My student is allergic to (include any food, medicine, or other known allergies): _____

My student has a medical condition (please explain): _____

In case of emergency, if I cannot be reached and my secondary emergency contacts cannot be reached, I authorize CHAMPS, the supervising staff member or the chaperone of the field trip to contact my student's physician directly.

Physicians Name: _____

Physician's Telephone Number (____) _____

Physicians Address: _____

I understand and accept all of the above medication procedures.

Parent/Guardian Signature

Parent/Guardian Name – Please print

Relationship to Student

Date



LOS ANGELES UNIFIED SCHOOL DISTRICT STUDENT EMERGENCY INFORMATION FORM

Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.

STUDENT'S LAST NAME			FIRST NAME			M.I.			
BIRTH DATE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		GRADE		HOME LANGUAGE			
STUDENT'S HOME ADDRESS -- NUMBER		STREET			APT #		CITY		ZIP CODE
MAILING ADDRESS -- NUMBER <small>(IF DIFFERENT FROM ABOVE)</small>		STREET			APT #		CITY		ZIP CODE
PARENT'S / LEGAL GUARDIAN'S LAST NAME		FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
WORK ADDRESS -- NUMBER		STREET			CITY			ZIP CODE	
CONTACT NUMBERS			Indicate which phone to call for each message type:*				EMAIL ADDRESS:		
HOME		EMERGENCY		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
CELL		ATTENDANCE		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
WORK		GENERAL INFO		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
PARENT'S / LEGAL GUARDIAN'S LAST NAME		FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
WORK ADDRESS -- NUMBER		STREET			CITY			ZIP CODE	
CONTACT NUMBERS			Indicate which phone to call for each message type:*				EMAIL ADDRESS:		
HOME		EMERGENCY		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
CELL		ATTENDANCE		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
WORK		GENERAL INFO		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work					
<i>To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:</i>									
NAME		RELATIONSHIP		HOME PHONE		CELL PHONE		WORK PHONE	
NAME		RELATIONSHIP		HOME PHONE		CELL PHONE		WORK PHONE	
NAME		RELATIONSHIP		HOME PHONE		CELL PHONE		WORK PHONE	
<i>List any other family members attending this school:</i>									
LAST NAME		FIRST NAME			HOME ROOM		GRADE	RELATIONSHIP	
LAST NAME		FIRST NAME			HOME ROOM		GRADE	RELATIONSHIP	
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT									
The undersigned, as parent/legal guardian of,								_____	a minor,
<small>(Print name of the student here)</small>									
hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Los Angeles Unified School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/guardian.									
HEALTH ALERTS -- List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".									
DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO* If "Yes": <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families									
MEDI-CAL / HEALTHY FAMILIES ID Number: _____									
1. PRIVATE HEALTH INSURANCE NAME			GROUP NO.		2. PRIVATE HEALTH INSURANCE NAME <small>(If covered under more than one plan)</small>			GROUP NO.	
NAME OF DOCTOR / MEDICAL OFFICE					PHONE NUMBER OF DOCTOR / MEDICAL OFFICE				
<small>*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.</small>									
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS: _____									
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS: _____									
I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.									
X _____							DATE		
SIGNATURE OF: (CHECK ONE) <input type="checkbox"/> PARENT <input type="checkbox"/> LEGAL GUARDIAN									

STUDENT'S LAST NAME

FIRST NAME

MIDDLE INITIAL

* Selected telephone number must be a direct dial number (no extensions).