



**SANTA CLARITA CHRISTIAN SCHOOL**

27249 Luther Drive, Santa Clarita, CA 91351  
661-252-7371 Fax 661-252-4354

# School Activity Permission Form

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Activity \_\_\_\_\_

Description of Activity \_\_\_\_\_ Overnight? \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Father's Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Cellphone \_\_\_\_\_

Mother's Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Cellphone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Are there any allergies or other physical conditions that are a factor for this activity?

\_\_\_\_\_

What medications are currently being taken and will be necessary to take during this activity?

\_\_\_\_\_

Whom to contact in the case of an emergency and you as parents cannot be reached:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

As the parent/guardian, I do hereby authorize the treatment by a qualified and licensed medical doctor of the above named student in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_