



UC Berkeley
Academic Talent
Development Program

FIELD TRIP PERMISSION FORM

BOTH SIDES OF THIS FORM **MUST** BE COMPLETED AND SIGNED BY THE PARENT OR GUARDIAN OF THE NAMED STUDENT

TO: Parent/Guardian

FROM: Lisa Kala, Interim Director

Your student, _____, has an opportunity to participate in a
field trip to _____.

☐ This trip counts toward the course's total hours of instruction; contact instructor immediately if student cannot attend

☐ This trip is optional and does not count toward the course's hours of instruction

DATE OF FIELD TRIP: _____

DEPARTURE TIME: _____

RETURN TIME (APPROXIMATE): _____

STUDENT WILL NEED TO BRING: _____

MODE OF TRANSPORTATION:

☐ Public transport (BART, MUNI)

☐ Walking

☐ Chartered Bus

☐ School Bus/Shuttle

Teacher's signature

Director's signature



I permit my son/daughter to participate in this field trip.

x

Parent/guardian's signature

PLEASE COMPLETE THE AUTHORIZATION FORM ON THE **REVERSE SIDE**

ACADEMIC TALENT DEVELOPMENT PROGRAM

UNIVERSITY OF CALIFORNIA, BERKELEY
2121 BERKELEY WAY, ROOM 2210
BERKELEY, CA 94720-1160

MAIN OFFICE: **510-642-8308** • OBAMA SCHOOL (ELEMENTARY DIVISION): **510-231-1456**



AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

BOTH SIDES OF THIS FORM **MUST** BE COMPLETED AND SIGNED BY THE PARENT OR GUARDIAN OF THE NAMED STUDENT

I, the undersigned, am the ☐ parent having legal custody of the minor named on the reverse side.
☐ legal guardian of the minor named on the reverse side.

I hereby authorize the ATDP course instructor into whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor under general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to the minor by a dentist licensed under the provisions of the Dental Practice Act.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority on the part of the ATDP course instructor to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician or dentist in the exercise of his or her best judgment may deem advisable.

I also understand that every reasonable effort will be made to obtain verbal permission from me prior to any such X-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of the State of California, and shall remain in effect until (indicate any date after the trip): _____ unless I sooner revoke it in writing.



Parent/guardian's name (please print)

x

Parent/guardian's signature

Date

ADDENDUM TO EMERGENCY INFORMATION

ATDP **must** have emergency information for all students. If you have not yet provided this information, fill out this form. You should also complete this form if:

- you have additional information that could be important while travelling
- you want to update information you sent earlier
- you aren't sure whether ATDP has this information

STUDENT'S NAME

RESIDENTIAL ADDRESS

HOME PHONE

()

PARENT'S
WORK PHONE

()

INSURANCE PROVIDER

POLICY NUMBER

MEDICATION(S)
STUDENT IS TAKING

MEDICATION STUDENT
CANNOT TAKE

IMPORTANT MEDICAL
HISTORY / NOTES