

Twain Harte-Long Barn USD
STUDY TRIP REQUEST
(All trips must comply with BP/AR 6153)

SCHOOL _____ DATE _____

Overnight study trip requests must be RECEIVED by the Superintendent one month prior to the date of the trip. PLEASE SEND BY SCHOOL MAIL ONLY, NOT BY FAX. Day study trip requests must be approved by the Principal and the Superintendent no later than the second Tuesday of the prior month to the trip.

GRADE LEVEL/GROUP _____ NO. IN CLASS _____ NO. ADULTS: _____

NAME (S) OF TEACHER (S) ACCOMPANYING GROUP _____ DATE OF TRIP (DAY AND DATE) _____

NAME (S) OF OTHER ADULTS ACCOMPANYING GROUP _____

TRIP REQUESTED TO (DESTINATION): _____

ADDRESS _____

HAVE ARRANGEMENTS BEEN MADE AT YOUR DESTINATION TO ACCOMMODATE THE GROUP? _____ YES _____ NO

WITH WHOM? _____ BY WHOM? _____

ARRANGEMENTS FOR TRANSPORTATION

BUS – District or Private

AUTOMOBILE

IF PRIVATE, WITH WHOM: _____

BY WHOM: _____

NO. BUSES: _____

Completed Automobile Transportation forms, having a legible copy of the driver's license and insurance card verifying the expiration date of coverage, must be submitted with the study trip request. If the automobile transportation forms are not submitted with the study trip request with all the above information completed, the study trip request will be returned to the school for completion, which will delay the approval of the request.

WHO FUNDED: Funding must be paid prior to the trip.

_____ District Funds _____ School Funds

_____ Other (Specify)

No. of paid class period substitutions requested

Lead Teacher _____ Date

Substitute to be charged to (Budget)

Principal _____ Date

Funding Source (If applicable)

Superintendent _____ Date

Please forward the original with the principal's signature and original copy of the Automobile Transportation forms with verification information attached, if by auto, to the Superintendent's Office.

**TWAIN HARTE-LONG BARN UNION SCHOOL DISTRICT.
STUDY TRIP ATTENDANCE LIST**

Teacher(s) _____

LIST OF STUDENTS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____

LIST OF STUDENTS (Continued)

28. _____
29. _____
30. _____
31. _____
32. _____
33. _____
34. _____
35. _____

PARENT VOLUNTEERS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

TWAIN HARTE-LONG BARN UNION SCHOOL DISTRICT

STUDENT PARTICIPATION IN DISTRICT-SPONSORED VOLUNTARY FIELD TRIP
PARENTAL PERMISSION, ASSUMPTION OF RISK, AND
MEDICAL TREATMENT AUTHORIZATION

Date: _____

Student's Name: _____ has permission to participate in the following field trip:

Destination/Nature of Activity: _____
(Please be specific, e.g., Concert at UCLA.)

Special Instructions: _____
(e.g., Bring sack lunch.)

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

Person in Charge: _____ Position: _____ School: _____

Type of Transportation: District Bus/Vehicle Walking Other: _____

COMPLETE FOR PRIVATE VEHICLES:
The undersigned gives their permission for this student to be a passenger in _____'s
(Driver's Name)
automobile while participating in this field trip.

Health or special needs: Check as appropriate.

_____ My student has no special health needs the staff should be aware of, and no medication is required on the trip.

_____ My student has a special need, and instructions are attached. Number of attached pages: _____

_____ Other: _____
(inhalers need a doctor's permission slip or RXs)

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and 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.

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip. As provided for in California Education Code Section 35330, I agree to waive all claims against the Twain Harte-Long Barn Union School District (District) and hold the District, its officers, agents and employees, harmless from any and all liability or claims, which may arise out of or in connection with my child's participation in this activity. This waiver shall not apply to any occurrences which may arise solely out of the negligence of the District, its employees or agents.

Signature (Parent/Guardian) _____ (Please Print Name) _____ Work Phone () _____
Home Phone () _____
Cell Phone () _____

Student's Signature _____ Student's Date of Birth _____

Family Medical Insurance Carrier: _____ Policy Number: _____

In the event of an emergency, please contact:

_____ (Name) _____ (Relationship) _____ Work Phone () _____
Home Phone () _____
Cell Phone () _____

TWIN HARTE-LONG BARN UNION SCHOOL DISTRICT
PARTICIPATION OF DISTRICT VOLUNTEER IN FIELD TRIP ACTIVITY
ASSUMPTION OF RISK AND MEDICAL TREATMENT AUTHORIZATION

Name: (Please print) _____

Destination/Nature of Activity: _____
(Please be specific, e.g., Attend concert at UCLA.)

Purpose of Your Attendance: _____ (Chaperone, etc.)

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

Method of Transportation: _____ School Bus/Vehicle _____ Walking _____ Other: _____

As provided for in California Education Code Section 35330, I agree to hold the Twain Harte-Long Barn Union School District (District), its officers, employees and agents harmless from any and all liability and claims arising out of or in connection with my participation in this activity. This waiver, however, shall not apply to any injuries or damages that arise solely out of the negligence of employees or agents of the District.

In the event of any illness or injury, I hereby consent to whatever x-ray, examination, anesthetic, medical, dental or surgical diagnosis and/or treatment, emergency transportation and hospital care from a licensed physician and/or surgeon as deemed necessary for my safety and welfare. It is understood that the resulting expenses will be the responsibility of the participant.

Signature _____ Date _____

Address: _____ Work () _____
Number _____ Street _____ Home () _____

City _____ State _____ Zip Code _____ Cell () _____

Health Insurance Company: _____ Policy #: _____
(e.g., Kaiser)

In the event of illness or accident, please notify:

Name: _____ Relationship: _____

Address: _____ Work () _____
Number _____ Street _____ Home () _____

City _____ State _____ Zip Code _____ Cell () _____

If there are any special medical instructions, kindly attach an explanation to this sheet.

To be signed by the Office Manager/Secretary:

TB Test Cleared _____

Fingerprints Cleared _____

Twain Harte-Long Barn Union School District
Transportation Department
18815 Manzanita Drive
Twain Harte, CA 95383
209-586-5871

FIELD TRIP SHEET

Activity trip requests must be submitted to the Transportation office no later than the Monday of the week prior to the date of the trip. We recommend that requests be submitted as early as possible to secure a bus and driver for your trip as they will be scheduled on a first come, first served basis.

DATE OF REQUEST _____

TEACHER(S) _____ GRADE(S) _____

DESTINATION _____ IN() OUT() OF COUNTY _____

TRIP DATE(S) _____ DEPARTURE FROM _____

OF STUDENTS _____ DEPARTURE TIME _____^{School Site} AM ___ PM ___

OF ADULTS _____ EXPECTED ARRIVAL _____ AM ___ PM ___

TOTAL _____ RETURN TO _____

RETURN TIME _____^{School Site} AM ___ PM ___

ADDITIONAL STOPS: Location/Time/Duration

- 1) _____
- 2) _____
- 3) _____

Type of transportation requested (Circle one) School Bus Private Car Van

ROUND TRIP () OUT ONLY () RETURN ONLY ()

TRANSPORTATION OFFICE USE ONLY

ESTIMATED COST OF TRIP _____

TRANSPORTATION APPROVAL _____ DATE _____

DRIVER _____ BUS # _____

Ending Mileage _____ Return Time _____

Beginning Mileage _____ Departure Time _____

Total Mileage _____ Total Time _____

Other Costs Parking _____ Food _____ Tolls _____ Other _____

Required safety instructions on back of this form.
For scheduling purposes, this form must be turned in to the transportation office at least 1 week prior to the trip.

**TWAIN HARTE-LONG BARN U.S.D.
AUTOMOBILE TRANSPORTATION FORM**

MAXIMUM OF NINE (9) STUDENTS REGARDLESS OF TYPE OR CAPACITY OF VEHICLE UNLESS DRIVER POSSESSES A VALID CALIFORNIA SCHOOL BUS DRIVER'S CERTIFICATE.

School _____ Date of Trip _____

Name of Driver _____ Registered Owner of Car _____

Car Insured By _____ Expiration Date _____

Insurance Policy Liability Limit _____

Total Number of Persons in: (Seatbelts are State Law)

CAR _____ STATION WAGON _____ MINIBUS _____

***Please do not write "Full". Write the dollar amount of insurance liability coverage on your vehicle. For verification, a copy of each driver's license and automobile insurance identification cards must be attached to each Automobile Transportation Form.**

NAMES OF STUDENTS TO BE TRANSPORTED:

(Please keep parents' approval to transport their child in a private vehicle in school file.)

The following section is quoted from the California Vehicle Code:

545. A "school bus" is a motor vehicle designed, used, or maintained for the transportation of any school pupil at or below the 12th-grade level to or from a public or private school or to or from public or private school activities, except the following:
- (a) A motor vehicle of any type carrying only members of the household of the owner thereof.
 - (b) A motor truck transporting pupils who are seated only in the passenger compartment, or a passenger vehicle designed for and carrying not more than 10 people, including the driver, unless the vehicle or truck is transporting two or more handicapped pupils confined to wheelchairs.

Additional guidelines:

Such a passenger vehicle is not exempt when transporting 10 or more pupils, or if the passenger vehicle is designed for more than 10 persons including the driver, and transporting one or more pupils. (Example: 12 or 15 passenger van cannot be used, even when transporting less than 10 students.)

District policy prohibits student drivers on any school sponsored activity or study trip.

When a parent/individual volunteers to transport students on a field trip during the school day, the parent/individual volunteer's liability insurance policy will be applicable and primary to any accidents, which may occur.

District policy requires acknowledgement and signature of driver regarding passenger restraints and air bags, which follows:

I understand that California law requires that "any child under the age of six years weighing less than 60 pounds, must be secured in a federally-approved child passenger restraint system" (car seat) "and ride in the back seat of a vehicle." I will comply with this law. I also understand that due to child deaths associated with the use of air bags, children 12 and under should sit in the rear seat whenever possible if the vehicle is equipped with an air bag.

Driver's Signature

FIELD TRIP MONIES COLLECTED

FIELD TRIP MONIES COLLECTED				
Teacher Name:				
Field Trip Name:				
Field Trip Date:				
	Date	Student Name	Amount	Cash or check
	1/1/2006	John Doe	\$10.00	Cash
1				
2				
3				
4				
5				
6				
7				
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9				
10				
11				
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Twain Harte-Long Barn Union School District

Request for Check

Vendor

Name: _____

Address: _____

Phone: _____

Fax: _____

Date: _____

Requestor

Name: _____

School: _____

Reason for Request

Principal: _____

Superintendent _____

Date: _____

Account: _____



ASCIP

Confidential School Accident Report Alliance of Schools for Cooperative Insurance Programs

12750 Center Court Drive, Suite 205 • Cerritos, CA 90703 • PH: (562) 403-4640 FAX: (562) 403-4644 • www.ascip.org

CONFIDENTIAL—ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE

This report is to be completed by school district employees. This form is a confidential, internal, document; its contents are not to be shared or copied for any persons who are not school district employees and/or their legal representatives.

IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY.

DATE OF REPORT

RESET FORM

NOTE: The school employee either witnessing the accident or supervising at the time should complete and submit this form within 24 hours. Please type or print using ball-point pen.

1 NAME OF SCHOOL DISTRICT		2 NAME OF SCHOOL	
ADDRESS OF SCHOOL (NUMBER, STREET, CITY AND ZIP CODE)			
3 NAME OF INJURED PERSON (LAST, FIRST, M.I.)		AGE	GRADE
		TELEPHONE NUMBER OF INJURED PERSON ()	
IS INJURED PERSON A MINOR <input type="checkbox"/> NO <input type="checkbox"/> YES	NAME OF PARENT OR LEGAL GUARDIAN		
4 ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)			
5 WHERE DID ACCIDENT OCCUR		DATE (MONTH/DAY/YEAR)	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
6 DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)			
7 FIRST AND LAST NAME OF PERSON IN CHARGE AT TIME OF ACCIDENT		TITLE OF PERSON (TEACHER, VOLUNTEER, ETC.)	WAS HE PRESENT AT THE TIME <input type="checkbox"/> YES <input type="checkbox"/> NO
			INJURED VIOLATED SCHOOL RULE <input type="checkbox"/> YES <input type="checkbox"/> NO
8 NAME OF WITNESS(ES)		ADDRESS	TELEPHONE NO. ()
			STATUS (Student, Volunteer, etc.)
			()
9 APPARENT NATURE OF INJURY (PLEASE CHECK)		10 INJURED PART OF BODY (PLEASE CHECK)	
<input type="checkbox"/> Abrasion <input type="checkbox"/> Fracture <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Contusion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation <input type="checkbox"/> Internal <input type="checkbox"/> Concussion <input type="checkbox"/> Other (explain) _____		<input type="checkbox"/> Head <input type="checkbox"/> Finger <input type="checkbox"/> Arm <input type="checkbox"/> Abdomen <input type="checkbox"/> Neck <input type="checkbox"/> Eye <input type="checkbox"/> Leg <input type="checkbox"/> Hand <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Face <input type="checkbox"/> Foot <input type="checkbox"/> Other (explain) _____	
11 FIRST AID PROCEDURES USED			NAME OF PERSON WHO ADMINISTERED FIRST AID
12 DISPOSITION OF INJURED AFTER ACCIDENT OR CLASS <input type="checkbox"/> Home <input type="checkbox"/> Doctor <input type="checkbox"/> Hospital <input type="checkbox"/> Classroom		13 WHO WAS NOTIFIED	RELATIONSHIP TO INJURED
14 IF INJURED PUPIL LEFT SCHOOL TO WHOM RELEASED		15 NAME AND ATTITUDE OF ANYONE CONTACTING SCHOOL	
16 STUDENT ACCIDENT BENEFITS AVAILABLE <input type="checkbox"/> YES <input type="checkbox"/> NO		17 REMARKS	
NAME OF COMPANY			

For your protection California law requires the following to appear on this form. "It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance; (b) prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding 3 years or by fine not exceeding \$1,000 or by both."

18 NAME OF PERSON COMPLETING REPORT		STATUS	TELEPHONE NUMBER OF PERSON ()
ADDRESS OF PERSON (NUMBER, STREET, CITY, STATE AND ZIP CODE)			PERSON WAS AN EYE WITNESS <input type="checkbox"/> YES <input type="checkbox"/> NO
SIGNATURE OF PERSON APPROVING REPORT		DATE SIGNED	

SUBMIT TO: CORVEL
P.O. BOX 277550, SACRAMENTO, CA 95827
ATTN: PAT VITALE - FAX: (916) 379-5598

Twain Harte - Long Barn Union School District
Health Services
BUMPS OR BLOWS TO THE HEAD

Date _____ School _____ Teacher _____

Dear Parent of : _____ received a bump, or blow, on his/her head on the
(Student Name)

_____ by _____
(Exact Area) (Describe accident, distance of fall, etc.)

at _____ a.m./p.m. today.

Since the effects of head injuries are sometimes delayed, continue to observe your child for the next 24 hours.

IF ANY OF THE FOLLOWING OCCUR, CALL YOUR FAMILY PHYSICIAN AT ONCE:

- | | |
|-------------------------------------|--|
| 1. Headache | 7. Fever over 100 degrees |
| 2. Persistent vomiting | 8. Unusual/increasing drowsiness |
| 3. Dizziness | 9. Blurred vision |
| 4. Weakness/paralysis of face/limbs | 10. Bleeding/fluid drainage from ears/nose |
| 5. Unconsciousness | 11. Change in behavior/personality |
| 6. Convulsions | |

Parent notified Time _____

REMARKS (including treatment):

(Person Providing Care)

FIELD TRIP CHECKLIST

Study Trip Request

- Study Trip Request
- Study Trip Request Education Value
- Study Trip Itinerary
- Study Trip Attendance List
- Student Participation/Parental Permission/Assumption of Risk and Medical Treatment Authorization
- Volunteer Field Trip Assumption of Risk & Medical Treatment Authorization
- Principal and Superintendent for day trips
- Board approval for overnight trips

Transportation Arrangements

- Bus Request
- Automobile Transportation Form
- Use of Private Vehicle Request Form

Money

- Send contract to District if any pre-payments are needed. If signed request, along with a copy of the contract, is received prior to noon on Tuesday, a check will be issued by the end of the week.
- Field Trip Monies Collected and instructions
- Request for Check to take with you (when possible, please make your request two weeks prior to the trip. In an emergency, we can issue a check within a couple of days)

Safety Kit

- Student Accident Forms (if bus is not staying, please be sure to have these forms with you)
- Bumps or Blows to the Head

Overnight Trips

- Myers-Stevens Short-Term (24-Hour) Coverage
You can get form from the secretaries. Rates may change from year to year.