✞ *Sunrise Beach School* ✞

Parent / Guardian Field Trip Agreement

Black Dawg Farm and Animal Sanctuary

12020 123Rd Ave SE, Rainer, WA 98576

Friday, October 27, 2023

Attending: Animal Husbandry Students

("All" Middle School Students Invited to Attend)

Leave School at 11:30 am / Return to School at 3:30 pm

Turn in this permission form by Wednesday, October 25th.

Ms. Tina Murray's Cellphone: (360) 522-1501

Students should bring lunch, snacks, and water.

Please also bring $5 - $10 to donate to the sanctuary.

Please check the weather report and dress appropriately with mud-proof footwear.

I/We give consent to Sunrise Beach School by this Limited Power of Attorney for Emergency Medical Authorization.

I/We have reviewed the field trip information and give permission for my child, _____, to participate and be transported by staff and parents on a field trip to the **Black Dawg Farm and Animal Sanctuary.**

I/We understand that all reasonable safety precautions will be taken by Sunrise Beach School staff and its agents but that there still exists an inherent possibility of an unforeseen accident, illness, injury and/or personal property loss to the mentioned child on this form.

☐ *Please check the box to indicate if you wish to chaperone your child on the trip. (I am willing to transport_____ students).*

Limited Power of Attorney for Emergency Medical Care Authorization

In the event the parent/guardian cannot be reached in a timely manner, given the emergency of the situation, this is to certify that Sunrise Beach School has the permission of the undersigned to authorize for the person named on this form, any medical care by an attending physician, or others he or she may choose, in the case of accidental injury, ingestion or illness. By my signature below, I hereby grant Sunrise Beach School and its representatives authority to give informed consent for the rendering of all necessary medical care to the named child, until such time I am able to personally contact those rendering the medical care. The undersigned accepts all financial responsibility for necessary treatment and services.

Employer: _____ Insurance Company: _____

Group/ Policy or Member Number: _____

Doctor's Name: _____ Phone: _____

Signed/ Relationship: _____/_____Date: _____