

ACKNOWLEDGMENT & ASSUMPTION OF POTENTIAL RISK
CONSENT TO TRANSPORT AND TREAT
Voluntary Sports Event/Activity

THIS FORM MAY NOT BE ALTERED IN ANY WAY

Permission for Voluntary Participation

_____ has my permission to participate in the activities listed below. I understand the following:

- 1. Participation in these activities is voluntary and is NOT required;
2. I may revoke this permission at any time by notifying the school district in writing; and
3. Revocation is not effective until receipt is acknowledged by the school district.
4. _____ (sport or activity), by its very nature, poses some inherent risk of a participant being seriously injured. These injuries could include, but are not limited to, the following:
5. The field trip / excursion may include but not be limited to:
a. Sprains/strains c. Cuts/abrasions e. Paralysis g. Head injuries i. Death
b. Fractured bones d. Unconsciousness f. Disfigurement h. Loss of eyesight

Consent to Transport

In accordance with California Education Code Section 35350, my signature below gives permission to transport (if applicable).

Consent to Treat

In the event of illness or injury, I hereby consent to whatever X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physicians and/or dentist and performed by or under the supervision of a member of the medical staff of the hospital, facility or office furnishing medical and/or dental services.

Initial all appropriate boxes below and provide additional information where necessary.

There are no special problems that the staff should be aware of and no medications are to be administered.

The following medication(s) is/are to be administered during this activity: _____. A physician's written instructions on dispensing must be attached to this form. All prescriptions, excepting those which must be kept on the student's person for emergency use, must kept and distributed by the staff.

My student has allergies, a special medical problem, or other participating-limiting factors, of which staff should be made aware: _____

No blood transfusions or blood products are to be given.

I fully understand that my student is to abide by all rules and regulations of conduct during this activity. Any violation of these rules and regulations may result in the school contacting me to arrange transportation home for my student at my full expense. I agree to hold the _____ School District, its employees, agents, volunteers and/or sponsors, and any other person, firm or corporation charged or chargeable with responsibility or liability free and harmless from any and all claims, demands, damages, costs, expenses, loss of services, action and causes of action resulting from the use of the facilities, equipment and participation by my son/daughter in the above named activity.

Signature of Parent/ Legal Guardian or Student over age 18

Date

Address where parent will be during activity

Phone where parent can be reached during activity

Under state law, school districts are required to ensure that all members of school athletic teams have accidental injury insurance that covers medical and hospital expenses. Some pupils may qualify to enroll in no-cost or low-cost local, state, or federally sponsored health insurance programs. Information about these programs may be obtained by calling 1-888-747-1222.

Medical examination and release has been completed on _____ by _____. Medical exams are required for all playing-field participants, including cheerleaders. Band members, team managers and ROP students (i.e., non-playing-field participants) are exempt from medical examination.

Parent's/Guardian's Health Insurance Company / MEDI-CAL

Policy number

Student's Primary Physician

Phone Number