

2010-2011

TRACY UNIFIED SCHOOL DISTRICT

EMERGENCY TREATMENT, EXTRA CURRICULAR ACTIVITY RELEASE AND CERTIFICATION OF VALID MEDICAL/HEALTH INSURANCE (form)

NOTE: THIS FORM MUST BE COMPLETED FOR EACH ACTIVITY/FIELD TRIP AND MUST BE SIGNED AND RETURNED TO THE APPROPRIATE SCHOOL, COACH, ADMINISTRATOR PRIOR TO PARTICIPATION IN THE IDENTIFIED ACTIVITY. NO VERBAL APPROVALS WILL BE ACCEPTED.

I, as the parent or guardian of \_\_\_\_\_, a student attending the Tracy Unified School District, at Merrill West High School, recognize the possibility of injury and resultant medical expenses due to participation in ALL SPORTS at Merrill West H.S. during the 2010-2011 school year. He/She has my permission to participate in the activity.

\*FALL SPORT \_\_\_\_\_ \*WINTER SPORT \_\_\_\_\_ \*SPRING SPORT \_\_\_\_\_
Name of sport Name of sport Name of sport

By checking the appropriate line and signing below, I acknowledge the following:

1. Our personal health or group insurance is adequate to pay for and reimburse us for medical, dental, hospital and surgical expenses that may be incurred due to injuries that may result from participation in the activity. I will continue this medical coverage in force throughout the time of the activity.

Policy #: \_\_\_\_\_ Company name: \_\_\_\_\_

2. I will purchase the Tracy Unified School District's Student Accident Plan provided through Assad Insurance Agency, by selecting the following:

Table with 4 columns: Description, Options (All plans are a ONE TIME annual payment), Low, High. Rows include At School Plan (Grades P-8, 9-12) and 24-Hour-A-Day Plan (Grades P-8, 9-12) with associated costs.

I hereby authorize the Tracy Unified School District and its authorized representatives to obtain or provide reasonable medical and/or emergency treatment for my child if he/she becomes ill or injured while participating in the extra curricular activity. I agree to release and hold harmless the District and its representatives from any and all liability resulting from such injury and/or treatment. (See California Education Code Sections 35330 and 49407). I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. I understand that the Tracy Unified School District, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_

PRINT NAME (Parent/Guardian): \_\_\_\_\_

ADDRESS AND PHONE NO: \_\_\_\_\_ DATED: \_\_\_\_\_

Please indicate any medical needs and/or information:

Medical needs/allergies, etc. (be specific/use attachment with instructions, if necessary)

Other needs: \_\_\_\_\_

Student Name Phone Number DOB Grade

