Twin Ridges Elementary School District

16661 Old Mill Road, Nevada City, California 95959

(530) 265-9052 Phone (530) 265-3049 Fax

ACKNOWLEDGEMENT & ASSUMPTION OF POTENTIAL RISK

Voluntary Sports Event or Activity

(Student)_____has my permission to participate in the activity listed below. I fully understand the following:

(Sport or activity) _____, by its very nature, poses some inherent risk of participant being seriously injured. These injuries could include, but are not limited to, the following:

1. Sprains/strains	2. Fractured bones	3. Cuts/abrasions
4. Unconsciousness	5. Paralysis	6. Disfigurement
7. Head injuries	8. Loss of eyesight	9. Death

All participants in this activity should understand that participation is voluntary and is not required by the school district.

The undersigned has read and hereby agrees to hold Twin Ridges 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 (student name) _____ in the above named sport.

List any medical conditions, allergies, or other limiting factors: _____

_____

_____

Medical examination release has been completed: _____

Family physician name: _____ Phone _____

Health insurance/MEDI-CAL per Education Code: 32220-32224: _____

Plan name and number: _____

In the event of illness or injury, I do hereby consent to medical/hospital treatments that are determined necessary in the best judgment of the attending physicians or dentists.

(Parent or Legal Guardian (if under 18) _____ Date: _____

Student Signature _____ Date: _____

* Medical exams recommended for all playing field participants (including cheerleaders); however, they are only required for high school. Band members, team managers and ROP students – i.e., non-playing field participants-are exempt.

TWIN RIDGES ELEMENTARY SCHOOL DISTRICT
Interscholastic Athletic Program
Permission Slip

As parent/guardian of _____, I (we) agree to have our child participate in the Twin Ridges ESD Interscholastic Athletic Program. To the best of our knowledge, the child named above is in good physical condition and no health or medical problems would prohibit his/her participation in the athletic program. In the event of emergency, the attached *Consent to Emergency Treatment* is authorized.

I am aware as the Parent/Guardian that I am responsible for transporting the above named student to and from all Twin Ridges ESD authorized athletic events. Due to financial constraints and non-availability, we are unable to utilize school buses for these trips. However, we will do our best to assist parent/guardian with a van when possible.

I understand that the Twin Ridges ESD does not provide medical insurance for student injuries but does offer student accident/health insurance for voluntary purchase. **I have received the information and application for this program.**

_____ _____

Signature of Parent/Guardian Date

CONSENT TO EMERGENCY TREATMENT

In the event I (we) cannot be readily contacted at _____ (phone number(s)), I (we) the undersigned parent(s)/guardian of _____, a minor, do hereby authorize agent(s) of the Twin Ridges ESD to initiate paramedic/ambulance care or transport for said minor and to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment and/or hospital care which is deemed advisable by, and is to be rendered under the general supervision of any dentist, physician or surgeon licensed under the provisions of the Medicine Practice Act of California, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

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.

This authorization shall remain effective until cancelled in writing and delivered to said agent. I understand that the Twin Ridges ESD, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of said minor. I further understand that all cost of paramedic/ambulance transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

Family Doctor	Address	Daytime Telephone Number
Health Plan/Insurance (i.e. Blue Cross, Kaiser, etc.)		Group Policy No.
My child is allergic to the following medications:		Medications Used:
My child has the following health problems:		
Signature of Parent or Guardian:		Date:

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