MEDICAL COVERAGE

EMERGENCY CONTACT

AUTHORIZATION FOR TREATMENT

Name: ______________________________________ Grade: _______________________

Date of Birth: _____ / _____ / _____

PROOF OF MEDICAL COVERAGE IS REQUIRED

Insurance Company ____

Policy Number _______________________________ Expiration Date ________________

PARENTAL/EMERGENCY CONTACT INFORMATION

____
Name

____
Address

____
City, State, Zip

____
Phone Number (Home)

____
Phone Number (Work)

____
Cellular Phone/Pager

____
E-mail

AUTHORIZATION TO TREAT A MINOR

I hereby give my consent for the above-named student to represent his/her school in athletic activities, and to accompany any school team of which he/she is member on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree we/I will not hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel. I am willing to assume all financial costs of any accident incurred by this student while participating in California School for the Deaf athletic program.

____
Parent/Guardian signature