**CURTIS CREEK SCHOOL DISTRICT**

**MEDICAL TREATMENT AUTHORIZATION**

**WAIVER, RELEASE AND INDEMNITY AGREEMENT**

**ASSUMPTION OF RISK FOR PARTICIPATION IN VOLUNTARY SPORTS PROGRAM**

**AND ATHLETIC INSURANCE CERTIFICATION FORM**

Student’s Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Activity:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates of Activity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature below, I hereby give permission for my son/daughter to participate in the above-described activity. I realize that this activity is voluntary as part of the Curtis Creek District sports program.  I understand that this activity could cause serious illness and/or injury or death, and I assume all risks for any such illness and/or injury or death.  I am aware of the transportation arrangements for this activity and acknowledge that if the school is providing no transportation, the parent has complete and sole responsibility for all transportation arrangements.  I am aware that the District does not provide coverage for medical treatment in connection with the activity. If a participant does not have private medical insurance, low-cost school insurance is available through the District.

For and in consideration of permitting the above named child to participate in the activity described above, the undersigned hereby voluntarily releases, discharges, waives and relinquishes any and all actions or causes of action for personal injury, bodily injury, property damage or wrongful death occurring to his/her child/ward or him/herself arising in any way whatsoever as a result of engaging in said activity or any activities incidental thereto wherever or however the same may occur and for whatever period said activities may continue.  The undersigned does for him/herself, his/her heirs, executor, administrators and assigns herby release, waive discharge and relinquish and action or causes of action, aforesaid, which may hereafter arise for him/herself and for his/her estate, and agrees that under no circumstances will he/she or his/her heirs, executors, administrators and assigns prosecute, present any claim for personal injury, bodily injury, property damage or wrongful death against the District or any of its officers, agents, or employees for any of said causes of action, whether the same shall arise by the negligence of any of said persons, or otherwise.

The undersigned hereby acknowledges that he/she knowingly and voluntarily assumes all risks of bodily injury to his/her child/ward or his/herself, as stated, and expressly acknowledges their intention, by executing this instrument, to exempt and relieve the District, its officers, agents, and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way he connected with the above-described activity. I have read and understand the foregoing and have voluntarily signed this agreement. I am aware of the potential risks involved in this activity and I am fully aware of the legal consequences of signing this instrument. I further acknowledge that the District does not automatically provide for medical coverage for participants in this activity.

Health or special needs:    Check as appropriate.

\_\_\_\_\_\_\_\_ Participant has no special health needs the staff should be aware of, and no medication is required.

\_\_\_\_\_\_\_\_ Participant has a special need, and instructions are attached.  Number of attached pages:  \_\_\_\_\_\_\_\_\_

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

I hereby certify, under penalty of perjury, that the above-named pupil is covered by valid insurance that provides the following:

1. Insurance protection for medical and hospital expenses resulting from accidental bodily injuries one of the following amounts: (Ed. Code 32221)
	1. A group or individual medical plan with accidental benefits of at least two hundred dollars ($200) for each occurrence and major medical coverage of at least ten thousand dollars ($10,000), with no more than one hundred dollars ($100) deductible and no less then eighty percent (80%) payable for each occurrence.
	2. Group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least one thousand five hundred dollars ($1,500).
	3. At least one thousand five hundred dollars ($1,500) for all medical and hospital expenses.
2. I hereby agree that this policy shall not be cancelable without at least 10 days prior written notice to the district.

Insurance protection in any of the above amounts shall be provided through group, blanket, or individual policies of accident insurance from authorized insurers or through a benefit and relief association, such as California Interscholastic Protection Fund, for the death or injury to members of athletic teams arising while such members are engaged in or are preparing for an athletic event promoted under the sponsorship or arrangement of the educational institution or a student body organization thereof or while such members are being transported by or under the sponsorship or arrangements of the school districts or a student body organization thereof to or from school or other place of instruction and the place of the athletic event.  Minimum medical benefits under any insurance required by this paragraph shall be equivalent to the three dollars and fifty cents ($3.50) conversion factor as applied to the unit values contained in the minimum fee schedule adopted by the Department of Industrial Relations of the State of California, effective October 1, 1966. (Ref. Ed. Code 32221)

I will maintain the above coverage during the current school year or will immediately notify the school if the coverage terminates or does not meet the above requirements.

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of member of the medical staff of the hospital or facility furnishing medical or dental services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE / DATE PARENT/GUARDIAN NAME – PLEASE PRINT PHONE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ADDRESS HEALTH PLAN PLAN #