MORGAN HILL UNIFIED SCHOOL DISTRICT
PARENT'S OR GUARDIAN'S PERMISSION
FOR STUDENT PARTICIPATION IN
EXTRACURRICULAR/ATHLETIC ACTIVITY
MEDICAL TREATMENT AUTHORIZATION

To the Principal of:____ (School)

____ has my permission to participate in
(Student Name: please print)

____ during the _____________________________________.
(Extracurricular/Athletic Activity) (School Year/Semester/Quarter)

Supervising Teacher / Coach (please print):____

I understand that the extracurricular/athletic activity, by its very nature, includes certain risks and could cause minor injury, major injury, and serious injury to student, including permanent disability and death. In the event of illness or injury to student, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, emergency transportation, and hospital care of student considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

_____ Student has no special health needs the staff should be aware of, and no medication is required during this class/activity.

_____ Student has a special need, and instructions are attached. Number of attached pages: _____.

_____ Other: ____

Medical Insurance Carrier: _________________________________ Policy Number: ________________________
(e.g., Blue Cross)

In the event of an **emergency**, please contact:

____________________________________ ___________________________ Work: ( ) _________________
(Name) (Relationship) Home: ( ) _________________
Cell: ( )_________________

________________________________	____________________________________	_______________
Signature of Parent/Guardian	**Please Print Name**	**Date**
________________________________	____________________________________	_______________
Signature of Student*	**Please Print Name**	**Date**

***IF STUDENT IS AGE 18 OR OLDER, STUDENT MUST COMPLETE THE INFORMATIONAL SECTIONS ABOVE AND COMPLETE & SIGN BELOW**

I certify that I am age 18 or older. I understand that the extracurricular/athletic activity, by its very nature, includes certain risks and could cause minor injury, major injury, and serious injury to me, including permanent disability and death. In the event of illness or injury to me, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, emergency transportation, and hospital care considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

_____ I have no special health needs the staff should be aware of, and no medication is required during this class/activity.

_____ I have a special need, and instructions are attached. Number of attached pages: _____.

_____ Other: ____

Medical Insurance Carrier: ___________________________________ Policy Number: ________________________
(e.g., Blue Cross)

In the event of an **emergency**, please contact:

_______________________________________ ____________________________ Work: ( ) ________ _________
(Name) (Relationship) Home: ( ) _________________
Cell: ( )_________________

________________________________ ____________________________________ _______________
Signature of Student **Please Print Name** **Date**

____
Age of Student