

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 OR 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 (school): _____, recognize the possibility of injury and resultant medical expenses due to participation in _____ (name of activity) at _____ on _____. He/She has my permission to participate in the activity. 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 Pacific Educators Insurance, 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 Pre-K-8, 9-12), 24-Hour-A-Day Plan (Grades Pre-K-8, 9-12), and Extended Dental Option.

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: _____

TUSD STAFF/PARENT/GUARDIAN : PLEASE INDICATE BELOW, BY CHECKING THE APPROPRIATE LINE, ANY SPECIAL NEEDS FOR STUDENTS WHILE PARTICIPATING IN THE DESIGNATED ACTIVITY SO THAT THE TUSD STAFF AND/OR PARENT/GUARDIAN MAY PROVIDE THE STUDENT WITH THE NECESSARY ITEMS.

Please provide student/child with the following: (items needed will be checked or specified)

- _____ Sack Lunch (parent/guardian: please provide a sack lunch for your child/children)
_____ My child will need a sack lunch provided by TUSD.
_____ Medical needs/allergies, etc.(be specific/use attachment with instructions, if necessary)

Other needs: _____

Student Name Phone No. DOB Grade/Room #

**Time Leaving: _____ Time Returning: _____ Transportation by: _____