Bishop Montgomery High School

Extra-Curricular Activities Permission Form & Permission to Provide Medical Treatment Agreement

(I)(We), the undersigned, parents of_____a minor, request that my son/daughter be permitted to participate in all of the following athletic team(s) functions as long as they are a student at BMHS. ***Physicals will be required each school year for sports participation (June-June). *Spirit Squads (April-April).***

With a current physical, (I)(We) give permission for my son/daughter to participate in <u>any</u> of the following sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Softball, Spirit Squads, Surf, Swimming/Diving, Tennis, Track and Field, Volleyball. <u>Please write in sport, if any, you do not want your son/daughter to participate in.</u>

(I)(We) understand that the events will be supervised by adults and the transportation will be by means of chartered bus, rental van, or possibly airliner. If chartered bus, rental van or airliner are not used, the responsibility for transporting my child to the event will be mine. BMHS shall provide the time and place of the event but under no circumstance will provide alternate transportation.

(I)(We) agree to direct my/our child to cooperate and conform with the directions and instructions of the supervisory personnel in charge of the event.

As a condition of being allowed to do so, I hereby release and discharge the school and its employees of any and all claims for personal injuries or property damage that my son/daughter may suffer as a result of participation described above, whether or not such injuries or damage are caused by the negligence(active or passive) of the school or its employees.

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(I)(We), hereby give permission for my son/daughter to undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in interscholastic athletics at Bishop Montgomery High School. I understand that the medical personnel of Bishop Montgomery High School, including athletic trainers and team physicians will perform only those procedures which are within their training, credential, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for my consent. I understand that if my child suffers a potentially life threatening injury or illness, and in the event I am unable to be contacted within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I have had the opportunity to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Extra Curricular Activities Permission Form and Permission to Provide Medical Treatment Agreement.

I agree to relieve the school and other participating adults from any liability in connection with this request.

This authorization is given in pursuant to the provisions of Section 25.8 of the Civil Code of California.
This authorization shall remain effective unless revoked in writing and delivered to said agents.

I understand that any insurance benefits that are effective have limited application.

<u>Parent/Guardian Information:</u> Please print in blue or black ink. Parent signature required on second page.

Parent/Guardian:_____Relationship to student:_____
Lives with student: Y N Parent Email_____
Place of Employment:_____Occupation:_____
Work phone( )_____ Cell( )_____Home phone( )_____

Parent/Guardian:_____Relationship to student:_____
Lives with student: Y N Parent Email_____
Place of Employment:_____Occupation:_____
Work phone( )_____ Cell( )_____Home phone( )_____

Student Information:

Student's Name:_____
Last First MI

Sex: M or F Birthdate:____/____/____ Home Phone:_____

Address:_____
Street Address City Zip

PLEASE LIST ANY MEDICATION YOUR CHILD IS TAKING, OR TAKES ROUTINELY:-

_____

_____

DOES STUDENT HAVE A HISTORY OF ANY ALLERGIES? (ie: medications, bee stings, food, environment) PLEASE LIST ALLERGIES:_____

_____

Emergency Contacts:

Other than parent(s)/guardian(s), who should be contacted in case of emergency?

1.Name:_____Relationship to student:_____
Home phone:_____Work phone:_____Cell:_____
2.Name:_____Relationship to student:_____
Home phone:_____Work phone:_____Cell:_____
3.Name:_____Relationship to student:_____
Home phone:_____Work phone:_____Cell:_____
4.Name:_____Relationship to student:_____
Home phone:_____Work phone:_____Cell:_____

Health Insurance Information:

Is student covered by health insurance? *Yes No* If yes, by which company?_____

(Guarantor: person who purchases insurance)

_____ _____
Guarantor's last name First Name Relationship to student

_____ _____
Guarantor's address City Zip Phone number

_____ _____ _____
Primary insurance co. Policy # Group #

_____ _____ _____ _____
Signature of Guardian Date Signature of Guardian Date

_____ _____
Printed name of Guardian Printed name of Guardian

_____ _____
Relationship to student Relationship to student

**A reproduction of this authorization shall be as valid as the original.

Please be sure to update this form with the Athletic Department should any information change prior to student's graduation.

PLEASE ATTACH A COPY(FRONT AND BACK)**OF YOUR STUDENT'S MEDICAL INSURANCE CARD.**