Roseville City School District
AFTER SCHOOL ATHLETIC PARTICIPATION CLEARANCE FORM

Student's Name	Activity	School Site

I hereby give my son/daughter permission to try out, practice and participate in the Roseville City School District After School Athletic Program.

I recognize that these activities may require strenuous physical exertion. I believe that my child is physically able to participate without damage to his/her health, and I release the Roseville City School District of any liability arising from any such physical activities.

I understand, acknowledge, and agree that the Roseville City School District, its employees, officers, agents, or volunteers, shall not be liable for any injury suffered by my son/daughter which is incident to and/or associated with the preparing for and/or participating is this activity.

In case of accident or other emergency if a parent/guardian cannot be reached, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment of my child, as he/she considers necessary. In the event that said doctor is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon. The undersigned hereby agrees to bear all costs incurred as a result of the foregoing.

SPECIAL INSURANCE NOTICE

California Education Code 32221 requires that any student of any "educational institution" who participates in any athletic event MUST BE INSURED FOR A MINIMUM OF $1,500.00 covering the medical expenses of accidental injuries. Students are not allowed to participate in athletic events until adequate insurance is in force, which meets the requirements of this law.

The information you fill out on the reverse side indicates that your family coverage will meet the requirements of the law.

OVER PLEASE

STUDENT'S NAME

Last	First	Middle	Birth Date	Grade	Sex

Address (Street/P.O. Box)	City	Zip	Home Phone

Father's Name	Father's Employer	Work Phone

Mother's Name	Mother's Employer	Work Phone

Name of Family Physician or Medical Advisor	Phone

Name of Health Plan	Group or Policy #	Phone

EMERGENCY CONTACTS – Persons who make act for parents when parents cannot be reached:

Name/Address	Phone

Name/Address	Phone

Medical Information:

*Does your child have any conditions/allergies/health problems, which could require emergency medical care? If so, please explain below:

*Is your child on any regular medication? If so, please list below:

PLEASE NOTE THAT PARTICIPATION WILL NOT BE ALLOWED UNTIL ADEQUATE COVERAGE IS PROVIDED. IF YOUR INSURANCE CHANGES OR IS DISCONTINUED, IT IS YOUR RESPONSIBILITY TO NOTIFY THE SCHOOL IMMEDIATELY.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS FORM AND UNDERSTAND AND AGREE TO ITS TERMS:

Parent/Legal Guardian Signature	Date

Student Signature	Date