COAST COMMUNITY COLLEGE DISTRICT AUTHORIZATION FOR MEDICAL TREATMENT

I, the undersigned (print name of student) ____ (Student/Participant) wish to (and if under 18 years of age also my parent or guardian authorize my son/daughter to) participate in the District-sponsored activity of **JUNIOR SAILING CAMP** (hereinafter "Activity"). In order that I, my daughter/son may receive the necessary medical treatment in the event of an emergency whereby I, she/he may sustain injury or illness during participation in this activity, I authorize any school official to consent to and obtain necessary medical treatment, including x-rays, examination, anesthetic, medical or surgical diagnosis or treatment or hospital care for such an injury or illness during the activity and I hereby release, discharge, indemnify and agree to hold District, District's governing board and College and each of their trustees, employees, agents, coaches, teachers, volunteers, and representative harmless in the exercise of such authority. I further hereby acknowledge that neither the District nor any of the persons named above have any obligation to seek such treatment.

Should the need arise; the following information may be given to any health care provider.

STUDENT

Name ____
(first) *(Middle)* *(Last)*

Address ____
(Street)

____
(City) *(State)* *(Zip)*

EMERGENCY CONTACTS

Parent(s) or guardian
Name ____
(first) *(Middle)* *(Last)*

Phone: *(including area code)* ____
(day)

____
(evening)

OTHER CONTACT

Name ____
(first) *(Middle)* *(Last)*

Relationship ____________________________

Phone: *(including area code)* ____
(day)

____
(evening)

STUDENT'S REGULAR PHYSICIAN

Name ____

Phone: *(including area code)* ____

MEDICAL CONDITION

Please list any medical conditions of the above student (asthma, diabetes, epilepsy, etc.)__________________________

Please list any Med allergies______________________________ Food/Env Allergies:______________________________

Please list any medications the above student is now taking. ____

List any medication the student is carrying to class:____

Date of the student's most recent tetanus shot____________________________

Other pertinent medical information:____

 Student Name____

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STUDENT HEALTH CHECK

In the past 14 days have you had:

1. Fever (100° F or greater)? __ Yes __ No
2. Shortness of breath? __ Yes __ No
3. Cough? __ Yes __ No

MEDICAL INSURANCE

Company:____ Policy No:_____________________________________

I, or the undersigned parent/guardian, have read and understood the above Authorization for Medical Treatment

____ ___________________

Signature of Parent or Guardian if Participant is under the Age of 18 *Date*

Student Age: _______ **DOB:** ____/____/____

Student Height:_______ Weight:____________

Student Shirt Size: _______________

Youth M L XL or Adult S M L XL

Student will attend with:

A sibling _____

A Friend _____ Name: ____________________

Please indicate weeks of prior sailing experience: ____

 Student Name____________________________________