COAST COMMUNITY COLLEGE DISTRICT AUTHORIZATION FOR MEDICAL TREATMENT

I, the undersigned (print name) _____ (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)

Name _____
(first) (Middle) (Last)

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 allergies or allergic reactions to medications of above student_____
Please list any medications the above student is now taking.
_____
Date of the student's most recent tetanus shot_____
Other pertinent medical information_____
_____

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*

_____
Signature of Participant *Date*

Student DOB: ____/____/____

Please indicate student t-shirt size:

Youth __ M __ L __XL

Adult __ S __M __L __XL