

CONFIDENTIAL

Fallbrook Union High School District

MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY

This form is provided to the coach and will be taken with the team wherever they travel. Please fill out completely and be specific. This form gives parental consent for any staff/chaperone approved by the school principal to secure emergency services (medical, dental, paramedic, ambulance) for the student at the parent/guardian expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization. An authorization with a physician's signature must be attached if the athlete takes any prescription medication.

Student Name:	Sport(s):	
Parent/Guardian Name:	Graduating Year:	
Address:	City/Zip:	
Home Phone:	Mother cell:	Mother work:
	Father cell:	Father work:

IN CASE OF EMERGENCY, A REPRESENTATIVE OF THE FUHSD ATHLETIC DEPARTMENT HAS THE AUTHORITY TO SECURE MEDICAL, OR SURGICAL TREATMENT AND TRANSPORT AS NECESSARY, EVERY ATTEMPT WILL BE MADE TO CONTACT THE EMERGENCY PERSONS LISTED BELOW

Family Doctor:	Dr. Phone #:
Emergency Person to Contact:	Phone #:
Relationship to Student:	
Emergency Person to Contact:	Phone #:
Relationship to Student:	

List all information helpful to a physician in case of emergency including information which school staff and chaperones need to be aware of regarding the student's safety. Updated information shall be provided by the parent/guardian

MEDICAL PROBLEMS (diabetes, asthma, seizures)	TREATMENT:
ALLERGIES (food, bee stings, medications)	TREATMENT:

SCHOOL RULES ARE IN EFFECT FOR ALL SCHOOL SPONSORED ACTIVITIES

MEDICATION: Prescription and non-prescription medications are permitted only with a written statement from the physician and parent/guardian indicating desire that the District assist the student as set forth by the physician. If prescription or non-prescription medication is necessary, an **AUTHORIZATION FOR MEDICATION ADMINISTRATION** must be attached. I understand that staff/chaperones may assist my student in taking the medicine(s) as directed by my physician. I will provide the medicine (s) in the prescription container(s) labeled with the name of my student, the prescribing physician's name, and the time and dosage of medication prescribed. I agree to hold harmless and indemnify the Fallbrook Unified High School District, its officers, employees, agents or chaperones from and against any and all liability, loss, expense or claims for illness, injury or damage any student may incur from medication assistance.

I UNDERSTAND THAT BY SIGNING THIS FORM:

1. I give permission for my son or daughter to participate in Fallbrook Unified High School District athletics.
2. I give permission for staff/chaperones to provide first aid care and secure emergency care at my expense if needed.
3. I release the Fallbrook Union High School District, its officers, employees, agents and its chaperones from any and all liability, loss, expense or claim for illness, injury or damages that may arise from participation in the athletics program or any associated activity. Further, I understand that the District does not provide accident/medical insurance for students and that I am expected to provide such insurance coverage.
4. I am aware that injuries may occur to the athlete while participating in interscholastic athletics. I have been advised of this danger.

Name of Insurance Company

Insurance Policy/Group number

X _____
Parent/Guardian Signature Date

X _____
Parent/Guardian Signature Date