



SCOTTS VALLEY HIGH SCHOOL 555 GLENWOOD DRIVE SCOTTS VALLEY CA 95066

Authorization for Treatment of a Minor and Release of Liability

Student Name _____ Birthdate _____ Gender _____

Parent/Guardian name(s) _____

Address _____ Home phone _____

Parent/Guardian cell #(s) _____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

Insurance Carrier _____ Group # _____

Suscriber Name _____ Member ID# _____

Name of Emergency Contact _____ Phone _____ Relation _____

Name of Emergency Contact _____ Phone _____ Relation _____

Medical Condition(s) of which emergency staff should be aware:

Sport _____ Coach name _____

A Copy of this authorization for care shall be as valid as the original.

Authorization to Treat A Minor;

In the event that I cannot be reached in an emergency, I hereby give consent to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care from a licensed physician and/or surgeon as deemed necessary for my child's safety and welfare. I understand that the resulting expenses will be the responsibility of the participant.

As stated in California Education Code Section 35330, I understand that the Scotts Valley Unified School District, its agents and employees will be held harmless from any and all liability or claims that may arise out of or in connection with my or my child's participation in this activity.

Parent/Guardian Signature _____ Date _____

Home number _____ Cell number _____