

EMERGENCY CONSENT & INSURANCE INFORMATION

EMERGENCY CONTACT INFORMATION

Student Birthdate _____ Grade _____

Athlete's Name _____ Cell/Home Phone _____

Address _____

Parent/Guardians Name _____ Cell Contact # (____) _____

Employer _____ Work Phone # _____

In the absence of parent/guardian, please call (in case of illness or accident) (____) _____

Emergency Contact Name _____ Relationship _____

INSURANCE AND PHYSICIAN INFORMATION

_____ My son/daughter (or ward) is covered for extracurricular/athletic activity under our family Health/Medical Plan that provides a minimum coverage of \$1 ,500 as required by *California Education Code* §32220-24. This is not administered by the school district.

TVCS is to be notified if insurance is terminated or changed

Insurance Company Name _____ ID/Policy/Group Number _____

Family Physician's Name _____ Phone Number (____) _____

Serious Medical Condition _____

Allergies (list) _____

CONSENT

___ Yes ___ No The student named above has my permission to engage in extracurricular/athletic/co-curricular activities, including travel.

ATHLETIC DIRECTOR/ATHLETIC TRAINER/ATHLETIC COACH/ATHLETIC ASSISTANT/EXTRA-CURRICULAR SUPERVISOR CONSENT

___ Yes ___ No I give my permission to the Athletic Director/Athletic Trainer/Athletic Coach/Athletic Assistant/Extracurricular Supervisor to administer immediate first-aid, follow-up treatment, and rehabilitation when appropriate in his/her professional judgment and/or as recommended by the consulting physician.

TREATMENT CONSENT

___ Yes ___ No In the event of accident or emergency, I (we) give permission for the school authorities to take my (our) child to any available doctor or hospital, or request their services I (we) grant consent to any healthcare providers to provide my (our) child with any necessary medical care as a result of any injury or illness

""IF YOUR ANSWER IS NO, PLEASE ADVISE THE SCHOOL AS TO WHAT ACTION YOU WOULD LIKE TAKEN:

I/We hereby consent that in the event that I/We cannot be reached in an emergency, I/We hereby grant permission to physicians selected by the coaches and staff of TVCS to secure proper treatment including hospitalization, injections, and/or anesthesia and surgery for the person named above. Any restrictions to this are listed below:

Parent/Guardian

Signature

Date