SYLVAN UNION SCHOOL DISTRICT
605 Sylvan Avenue
Modesto, CA 95350

AFTER SCHOOL RECREATION
STUDENT PARTICIPATION APPLICATION

NAME OF STUDENT: _____ DATE: _____

SCHOOL: _____ GRADE: _____

ADDRESS: _____ PHONE NUMBER: (____) _____

SPORT / ACTIVITY APPLYING FOR: _____

NAME OF EMERGENCY CONTACT: _____ PHONE: _____

NAME OF EMERGENCY CONTACT: _____ PHONE: _____

TO THE PARENT/GUARDIAN:

Students participating in school-sponsored and supervised interscholastic athletics are required to have medical insurance coverage per Education Code 49470.

Was medical insurance coverage purchased through the school for your child? ☐ Yes ☐ No

If your child has private medical insurance coverage, please attach a copy of the medical card to this form as proof of insurance.

My child, _____ has my permission to participate in the After School Recreation Program being offered by Sylvan Union School District. I also give permission for my child to travel to other schools for interscholastic competition.

I understand that my child will be responsible for any uniform and/or equipment which is checked out to them.

Transportation to other schools for interscholastic competition may be provided or I may transport my own child. Parents MAY NOT transport children other than their own.

_____ _____
Signature of Parent/Guardian Date

STUDENT INFORMATION SHEET

FULL NAME OF STUDENT: _____ DOB: _____

ADDRESS: _____

FATHER'S NAME: _____ FATHER'S EMPLOYER: _____

CELL PHONE #: _____ WORK PHONE #: _____

MOTHER'S NAME: _____ MOTHER'S EMPLOYER: _____

CELL PHONE #: _____ WORK PHONE #: _____

MEDICAL HEALTH INSURANCE CARRIER: _____

GROUP NAME: _____ GROUP NUMBER: _____

POLICY #: _____

NAME OF PHYSICIAN: _____

PHYSICIAN ADDRESS: _____ PHONE NUMBER: _____

ALLERGIES TO ANY FOODS/MEDICATIONS: _____

ANY SPECIAL HEALTH NEEDS/PROBLEMS: _____

_____

_____

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent(s) or legal guardian(s) of the above named student do herby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency staff licensed under the provisions of the Medical Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the California Department of Public Health.[3]

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization being required, but given to provide authority and power to render care which is aforementioned physician in the exercise of his or her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

_____ _____

Signature of Parent/Guardian Date