2011-2012

TRACY UNIFIED SCHOOL DISTRICT

EMERGENCY TREATMENT, EXTRA CURRICULAR ACTIVITY RELEASE AND CERTIFICATION OF VALID MEDICAL/HEALTH INSURANCE (form)

NOTE: THIS FORM MUST BE COMPLETED FOR EACH ACTIVITY/FIELD TRIP AND MUST BE SIGNED AND RETURNED TO THE APPROPRIATE SCHOOL, COACH, ADMINISTRATOR PRIOR TO PARTICIPATION IN THE IDENTIFIED ACTIVITY. NO VERBAL APPROVALS WILL BE ACCEPTED.

I, as the parent or guardian of:_____, a student attending the Tracy Unified School District, at **Kimball High School** recognize the possibility of injury and resultant medical expenses due to participation in SPORTS **during the 2011-2012 school year.** He/She has my permission to participate in the following sport activity:

(Fall Sport)_____(Winter Sport) _____(Spring Sport) _____
(Name of Sport) (Name of Sport) (Name of Sport)

By checking the appropriate line and signing below, I acknowledge the following:

_____ 1. Our personal health or group insurance is adequate to pay for and reimburse us for medical, dental, hospital and surgical expenses that may be incurred due to injuries that may result from participation in the activity. I will continue this medical coverage in force throughout the time of the activity.

Policy #:_____ Company name:_____.

_____ 2. I will purchase the Tracy Unified School District's Student Accident Plan provided through Assad Insurance Agency, by selecting the following:

See Pacific Educators Voluntary Student Accident Insurance brochure for more details	Options (All plans are a ONE TIME annual payment)	Low	High
	At School Plan		
www.peinsurance.com	Grades P-8	$10.00	$23.00
	Grades 9-12	$22.00	$50.00
800-722-3365	**24-Hour-A-Day Plan**		
	Grades Pre-K-8	$70.00	$150.00
	Grades 9-12	$86.00	$179.00
	Optional Tackle Football Coverage		
	Grade 9	$34.00	$75.00
	Grades 10-12	$78.00	$165.00
	Extended Dental Option (medical must be purchased. Coverage cannot stand alone)	$6.00	---------

I hereby authorize the Tracy Unified School District and its authorized representatives to obtain or provide reasonable medical and/or emergency treatment for my child if he/she becomes ill or injured while participating in the extra curricular activity. **I agree to release and hold harmless the District and its representatives from any and all liability resulting from such injury and/or treatment. (See California Education Code Sections 35330 and 49407).** I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. I understand that the Tracy Unified School District, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

SIGNATURE OF PARENT/GUARDIAN: _____

PRINT NAME (Parent/Guardian):_____

ADDRESS AND PHONE NO:_____DATED: _____

TUSD STAFF/PARENT/GUARDIAN : PLEASE INDICATE BELOW BY CHECKING THE APPROPRIATE LINE ANY SPECIAL NEEDS FOR STUDENTS WHILE PARTICIPATING IN THE DESIGNATED ACTIVITY SO THAT THE TUSD STAFF, PARENT/GUARDIAN MAY PROVIDE THE STUDENT WITH THE NECESSARY ITEMS.

Please provide student/child with the following: (items needed will be checked or specified)

_____ Medical needs/allergies, etc.(be specific/use attachment with instructions, if necessary)

Other needs: _____

_____ _____ _____ _____
Student Name Phone No. DOB Grade/Room #

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