

SAN FRANCISCO COMMUNITY COLLEGE DISTRICT
PARTICIPATION IN INTERCOLLEGIATE SPORT
MEDICAL TREATMENT AUTHORIZATION

Athlete's Name: _____ and Student ID _____
hereby requests permission to participate in the following:

Intercollegiate Sport: _____

Instructor/Coach: _____

I understand that the class/activity/intercollegiate sport, by its very nature, includes certain risks and could cause minor injury, major injury, and serious injury, including permanent disability and death. In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, emergency transportation, and hospital care considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

I further acknowledge that the District does not provide liability or medical insurance coverage for participants who participate in this class/activity/intercollegiate sport.

_____ I have no special health needs the staff should be aware of, and no medication is required during this class/activity/intercollegiate sport.

_____ I have a special need, and instructions are attached. Number of attached pages: _____.

_____ Other: _____

Medical Insurance Carrier: _____ Policy Number: _____
(e.g., Blue Cross)

In the event of an **emergency**, please contact:

_____	_____	Work: () _____
(Name)	(Relationship)	Home: () _____
		Cell: () _____

Signature of Student/Participant

Please Print Name

Date

Signature of Parent/Guardian (If student is under age 18)

Please Print Name

Date