SAN FRANCISCO COMMUNITY COLLEGE DISTRICT
PARTICIPATION IN A CLASS/ACTIVITY
MEDICAL TREATMENT AUTHORIZATION

Student's/Volunteer's Name: ________________________ and Student ID _______________________ hereby requests permission to participate in the following college class/activity:

CRN# _____________________ SUBJECT: ____________________ INSTRUCTOR: ____________________

Class/activity description: ____

____

I understand that the class/activity, 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.

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

_____ 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**