ALPINE SCHOOL DISTRICT

Consent and Authorization Form

Name of Participant _____ Date of Birth _____

Home Address _____

Home Phone _____ Parent's Business Phone _____

CONSENT TO PARTICIPATE

I give my consent for the above named student to participate in the following activity of Alpine School District:

_____

_____

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize _____ or any other school supervisor involved in the above named activity, as my agent(s) to consent to any necessary emergency medical or dental treatment. This authorization shall remain effective until _____ .

Date

_____ _____

Date Signature of Parent or legal Guardian

MEDICAL INFORMATION TO BE USED AS NECESSARY

Health and Accident insurance in force (Company) _____

Do you have or require any of the following:

Special Diet?	Yes ☐	No ☐	Allergies?	Yes ☐	No ☐		
Chronic or recurring illness?	Yes ☐	No ☐	Medication?	Yes ☐	No ☐		
Physical Condition that would limit activity?				Yes ☐	No ☐		
Has the student had surgery or a serious illness in the past year?				Yes ☐	No ☐		

If the answer is yes to any of the above, give full particulars of each. (Use the back of this form if necessary) Please supply any other information which should be known by the supervising teacher.

_____

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