PLACENTIA-YORBA LINDA UNIFIED SCHOOL DISTRICT
1301 E. Orangethorpe Ave. Placentia, Ca. 92870

STUDENT PARTICIPATION IN VOLUNTARY VALENCIA HIGH SCHOOL DANCE CLINIC

PARENTAL PERMISSION & MEDICAL TREATMENT AUTHORIZATION

________________________ has permission to participate in the following DANCE CLINIC
(Student's Last Name) (Student's First Name)

On (Date): Saturday 4/21/18 at Valencia High School

Health or Special Needs: *Check as appropriate.*

- ☐ My child has NO special needs the staff should be made aware of, and NO medication is required for this clinic
- ☐ My child has a special need and/or medication required during this clinic.

NOTE: Attach instructions and location of medication. Number of attached pages:
It is the responsibility of the parent to notify the school of any changes to their child's medication(s).

- ☐ Allergies. List:
- ☐ Other:

RELEASE NOT TO FILE A CLAIM/AUTHORIZATION TO TREAT A MINOR

For and in consideration of permitting the above named child to participate in the activity described above, I/we the undersigned, for him/herself and personal representatives, assigns, heirs, and next of kin, as well as for any minor for whom this Release and Covenant Not to File a Claim is executed, or that minor's personal representative, assigns, heirs and next of kin, hereby voluntarily RELEASES, WAIVES, DISCHARGES, AND COVENANTS NOT TO FILE A CLAIM against the Placentia-Yorba Linda Unified School District, its agents or employees, or the State of California for any injury, accident, illness or death occurring during or by reason of the activity, or any activities incidental to the field trip or excursion that is the subject of this authorization (Education Code Section 35330). The undersigned hereby acknowledges that he/she has been advised of all rules and safety regulations pertaining to this activity and the use of protective equipment by all participants. I/we understand these safety regulations will be enforced during all games and practices. I/we fully understand that participants are to abide by all rules and regulations governing conduct during this activity.

I/We the undersigned parent, parents, or legal guardian of the above named child, a minor, do hereby 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 room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health, (only if we have given permission above to receive medical attention and admission to a hospital for a medical emergency). It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his 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. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. I/We agree to assume financial responsibilities for injuries sustained by my child.

I/We understand this field trip, activity, or event may be cancelled at any time for security reasons. Such trips are subject to modification or cancellation when the U.S. Dept. of Homeland Security announces either High Condition (Orange) or Severe Condition (Red). In the event of such cancellation by the District, I/we accept any and all financial risks or penalties imposed by any of the vendors providing services for travel, accommodations, or other trip-related services as a result of cancellation.

Parent/Guardian Signature ____________________ Parent/Guardian Print Name ____________________

Home Phone: (_____) ____________________ Work Phone: (_____) ____________________

____________________ Student's Date of Birth: ____________________

Student's Signature if 18 or over, or if emancipated minor

Name of Physician: ____________________ Phone Number: ____________________

Medical Insurance Company: ____________________ Policy Number: ____________________

(e.g., Kaiser) For Religious Accommodation, a copy of the appropriate form must be attached.

If Parent/Guardian is not available, please notify:

Name: ____________________ Relationship: ____________________

Home Phone: (_____) ____________________ Work Phone: (_____) ____________________

If you wish to purchase student accident, medical and hospitalization insurance, please contact your school office.