

HOLY FAMILY CATHOLIC SCHOOL
ACTIVITY PERMISSION FORM
 7817 Old Auburn Road Citrus Heights, CA. 95610 (916) 722-7788

Check all activities trying out for this year: (5th - 8th Grades)

- | | | | |
|--|--------------------------------------|--|-------------------------------|
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Cheerleader | <input type="checkbox"/> Flag Football | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Track & Field | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Bowling (gr. 4-8) | (Bowling not a PAL sport) |

Student's Name _____ Grade _____

Mother's Name _____ Home/Cell # _____
 (Please Print)

Work # _____ Email _____

Address _____
 Street City State Zip

Father's Name _____ Home/Cell# _____

Work # _____ Email _____

Address _____
 Street City State Zip

Guardian's Name _____ Home/Cell# _____

Work # _____ Email _____

Address _____
 Street City State Zip

IN CASE OF AN EMERGENCY, PLEASE CONTACT _____

EMERGENCY # _____ **RELATIONSHIP TO CHILD** _____

I, the parent/guardian of the above student, hereby, give my permission for his/her participation in the activities named above. I agree to direct my child to cooperate with directions and instructions of the coaches responsible for these activities.

I agree that in the event student is injured as a result of his/her participation in any of the above activities, recourse for payment of any resulting hospital, medical or related costs and expenses will first be against any accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

I am aware of any medical condition of my child that would render it inappropriate for him/her to participate in such activities.

AUTHORIZATION OR EMERGENCY TREATMENT OF A MINOR: In the case of a serious emergency and none of the above persons can be contacted. I authorize the school official to call my family doctor. If the situation demands to transfer my child to the nearest hospital for the necessary emergency care, I consent to any x-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by and is rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medicine Practice Act and on the Medical Staff of a certified hospital whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that Holy Family Catholic School does not assume responsibility for payment of a physician or of treatment. If our family physician cannot be reached the school may choose a physician.

Parent/Guardian Signature _____ Date _____

I DO NOT GIVE AUTHORIZATION FOR EMERGENCY TREATMENT

Parent/Guardian Signature _____ Date _____