2024-2025 School Year CORONA-NORCO UNIFIED SCHOOL DISTRICT

ATHLETIC TRANSPORTATION PERMIT

[ ] Band [ ] Orchestra [ ]Color Guard *Use a ballpoint pen. Please Print Clearly*

Student: _____ **Student #:** _____ **School: Santiago High School**

Dear Parent/Guardian:

Your consent is required to permit your child to be transported for band/orchestra/colorguard activities. No student will be permitted to participate in activities off campus without a signed permission slip.

[ ] I DO permit my child to be transported by the Corona-Norco Unified School District or District approved charter bus service.

I hereby grant permission for the District to allow emergency medical treatment if required and accept liability for such treatment. As stated in California Education Code Section 35330, I understand that I hold the Corona-Norco Unified School District, its officers, agents and employees harmless from any and all liability and claims, which may arise out of or in connection with my child's participation in this activity.

AUTHORIZATION FOR EMERGENCY MEDICAL CARE (WAIVER)

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority, when parents or guardians cannot be easily reached.

1. STUDENT NAME: (Last)_____(First)_____ (m.i.)_____

GRADE: _____ ADDRESS: _____ SEX: ____ AGE: ___ DATE OF BIRTH:_____.

CITY: _____ ZIP: _____ PHONE: _____

2. FATHER'S NAME: _____ PHONE: _____ CELL: _____.

EMPLOYER: _____ PHONE: _____.

3. MOTHER'S NAME:_____ PHONE: _____ CELL: _____.

EMPLOYER: _____ PHONE: _____

4. Name of person, other than parent or guardian, who is authorized to approve emergency medical treatment:

_____ PHONE: _____.

5. FAMILY DOCTOR:_____ PHONE: _____.

HEALTH INSURANCE CO.:_____ POLICY I.D.#:_____.

In the event reasonable attempts to contact me/us at the above locations, or other person(s) named in item 4 above fail, full authorization is given for (1) the administration of any treatment deemed to be necessary by a medical practitioner; and (2) the transfer of son/daughter or ward to any medical practitioner; and (3) the transfer of son/daughter or ward to any licensed hospital or emergency clinic reasonably accessible. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and given to provide Authority and Power on the part of school authorities and aforesaid agent(s) to give reasonable care. Facts are given below concerning the student's medical history which a medical practitioner should know.

Allergies: _____Allergies to specific medication(s): _____

Any previous significant medical problems:_____

Sickle Cell Trait/Disease: [ ] Yes [ ] No Asthma: [ ] Yes [ ] No

_____ _____

Parent / Guardian Signature Date