

CORONA-NORCO UNIFIED SCHOOL DISTRICT

2025-2026 School Year

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: _____ Student PHONE: _____

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

EMPLOYER: _____ PHONE: _____

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

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