George A. Buljan Middle School
California Distinguished School
100 Hallissy Drive
Roseville, CA 95747
Phone: 916-771-1720
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Brian Thompson, Principal
Sara Carrari, Assistant Principal
Daniela Barajas Mena, Assistant Principal

AFTER SCHOOL ATHLETIC PARTICIPATION CLEARANCE FORM

_____	_____	_____
Student's Name	Activity	School Site

I hereby give my son/daughter permission to try out, practice, and participate in the Roseville City School District After School Athletic Program.

I recognize that these activities may require strenuous physical exertion. I believe that my child is physically capable of participating in these activities without harm to their health, and I release the Roseville City School District from any liability arising from such participation.

I understand, acknowledge, and agree that the Roseville City School District, its employees, officers, agents, or volunteers, shall not be liable for any injury suffered by my son/daughter which is incident to and/or associated with the preparing for and/or participating in this activity.

In the event of an accident or other emergency, if a parent/guardian cannot be reached, I hereby authorize a representative of the school to make such arrangements as they consider necessary for my child to receive medical or hospital care, including transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment of my child as he/she considers necessary. If said doctor is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon. The undersigned hereby agrees to bear all costs incurred as a result of the foregoing.

SPECIAL INSURANCE NOTE

California Education Code 32221 requires that any student of any "educational institution" who participates in any athletic event MUST BE INSURED FOR A MINIMUM OF $1,500.00, covering the medical expenses of accidental injuries. Students are not allowed to participate in athletic events until adequate insurance is in force, which meets the requirements of this law. If your child needs athletic insurance, please contact the school office.

The information you fill out on the reverse side indicates that your family coverage will meet the requirements of the law.

STUDENT INFORMATION

Student's Last Name	First	Middle	Birth Date	Grade	Sex

Address (Street/P.O. Box), City, Zip _____ Home Phone _____

Father's Name _____ Father's Email _____ Work Phone _____

Mother's Name _____ Mother's Email _____ Work Phone _____

Name of Family Physician or Medical Advisor _____ Phone _____

Name of Health Plan _____ Group or Policy # _____ Phone _____

EMERGENCY CONTACTS - Persons who act for parents when parents cannot be reached:

Name/Address _____ Phone _____

Name/Address _____ Phone _____

Medical Information:
*Does your child have any conditions/allergies/health concerns that could require emergency medical care? If so, please explain below:

*Is your child on any regular medication? If so, please list below:

PLEASE NOTE THAT PARTICIPATION WILL NOT BE ALLOWED UNTIL ADEQUATE COVERAGE IS PROVIDED. IF YOUR INSURANCE CHANGES OR IS DISCONTINUED, IT IS YOUR RESPONSIBILITY TO NOTIFY THE SCHOOL IMMEDIATELY.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS FORM AND UNDERSTAND AND AGREE TO ITS TERMS:

Parent/Legal Guardian Signature _____ Date _____

Student Signature _____ Date _____