

ANDERSON UNION HIGH SCHOOL DISTRICT
AUTHORIZATION TO CONSENT TREATMENT OF A MINOR

ATHLETIC TRAVEL CARD
2026-2027

_____ <i>Student Name</i>	_____ <i>Emergency Phone #</i>
_____ <i>Street Address</i>	_____ <i>Family Doctor</i>
_____ <i>City, State, Zip Code</i>	<i>Has the student ever attended another High School?</i> Yes No <i>If yes, please state which High School:</i> _____

MEDICAL INFORMATION

Name of Preferred Physician

List any Drug Allergies

List any Physical Disabilities

List any Regularly Taken Medications

List any Medical Problems

Please select a preferred hospital:
 Mercy **Shasta Regional** **St. Elizabeth**

INSURANCE INFORMATION (Required)

Insurance Provider (Required)

Policy Number (Required)

EMERGENCY CONTACTS

_____ <i>Emergency Contact Name</i>	_____ <i>Phone Number</i>	_____ <i>Relationship to Student</i>
_____ <i>Emergency Contact Name</i>	_____ <i>Phone Number</i>	_____ <i>Relationship to Student</i>

AUTHORIZATION

I/We, the undersigned parent/guardian of the above mentioned minor student do hereby authorize the faculty member of the Anderson Union High School District supervising the activity concerned, as agent for the undersigned, to consent to an x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of any physician and surgeon licensed under the provision of the Medical Practice Act on the medical staff of any licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care required but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California. This authorization shall remain effective until the end of the school year in which it was signed.

Parent/Guardian Signature

Date

Anderson Union High School District

1469 Ferry Street, Anderson, CA 96007
530/378-0568 • www.auhsd.net



*Every Student Will Learn
Every Graduate Will Be College
and Career Ready*

AUTHORIZATION & CONSENT FOR MEDICAL TREATMENT
AND HEALTH INSURANCE VERIFICATION

HEALTH INSURANCE:

Pursuant to Education Code 32221, the insurance shall provide the following coverage:
At least one thousand five hundred dollars (\$1,500) for all medical and hospital expenses.

I have health insurance that meets the requirements under the California Education Code Section 32221.

Student's Name: _____
Insured (Subscribers) Name: _____
Insurance Company *(Required)*: _____
Policy/I.D. Number *(Required)*: _____

California Education Code 32221.5: Some students may qualify to enroll in no-cost or low-cost local, state, or federally sponsored health insurance programs. Information about these programs may be obtained by calling Medi-Cal at 800-541-5555 or Healthy Families Program at 888-599-7056.

AUTHORIZATION & CONSENT FOR MEDICAL TREATMENT

In the event of an injury or illness to _____ while participating on the athletic team, I do hereby authorize the Anderson Union High School District, as agent for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and/or surgeon, whether such diagnosis or treatment is rendered at the office of said physician or at any medical facility.

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 on the part of the aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization shall remain effective through the conclusion of the sport season, including any playoff or championship competition, unless revoked in writing and delivered to said agent.

Parent/Guardian Signature

Date

Student Signature

Date



ATHLETICS / SPORTS VOLUNTARY ACTIVITIES PARTICIPATION FORM
ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

CONSENT TO PARTICIPATE

Athlete's Name: _____

Parent/Guardian Name: _____

Address: _____ City, State: _____

Home Phone: _____ Cell Phone: _____

By its very nature, sports, including tryouts, may put students in situations in which serious catastrophic and perhaps fatal accidents may occur. Students and parents must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution, or supervision will totally eliminate the risk of injury. Just as driving an automobile involves the risk of injury; participation in sports by students involves some inherent risk. The importance of your awareness of these risks in determining whether or not to allow your child to participate cannot be overstated. There have been accidents in sports, resulting in death, paraplegia, quadriplegia, and other very serious permanent physical impairments as a result of athletic participation.

Students will be instructed in proper techniques and in the proper utilization of all equipment or work used in practice and competition. Students must adhere to that instruction and utilization and must refrain from improper uses and techniques.

No amount of instruction, precaution, and supervision can eliminate all risk of injury, including serious, injury. Some of the injuries/illnesses which may result from participating in these activities include, but are not limited to, the following:

- | | |
|-----------------------------|----------------------------|
| 1. Sprains/strains | 7. Loss of eyesight |
| 2. Fractured bones | 8. Communicable diseases |
| 3. Unconsciousness | 9. Internal organ injuries |
| 4. Head and neck injuries | 10. Brain damage |
| 5. Neck and spinal injuries | 11. Death |
| 6. Paralysis | |

By signing this waiver, you acknowledge that you understand and accept such risk and authorize the student named above to participate in sports. By choosing to participate, you acknowledge that such risks exist.



ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

I authorize my student to participate in District sponsored sports and activities.

I have read this form in its entirety and understand its contents. I understand that it is my obligation to ask questions about anything I do not understand.

I understand and acknowledge that participation in sports is completely voluntary and as such is not required by the District for course credit or for completion of graduation requirements.

I agree to assume financial responsibility for any medical costs and expenses incurred as a result of any injury that may be sustained by my child while participating in sports.

I understand, acknowledge and agree that the Anderson Union High School District, its elected or appointed officials, employees, agents or volunteers shall not be liable for any injury/illness suffered by my son/daughter which is incident to and/or associated with preparing for and/or participating in this activity and I voluntarily assume all risk, known or unknown, of injuries, howsoever caused, even if caused in whole or in part by the action, inaction, or negligence, of the released parties to the fullest extent allowed by law.

I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES PARTICIPATION FORM and that I understand and agree to the terms.

Parent/Guardian Signature

Date

Student Signature

Date

A signed VOLUNTARY ACTIVITIES PARTICIPATION FORM and AUTHORIZATION & CONSENT FOR MEDICAL TREATMENT AND HEALTH INSURANCE VERIFICATION FORM must be on file with the Anderson Union High School District before a student will be allowed to participate in the above extra-curricular activities.

Student Name

Parent/Guardian Name

Activities

Students shall always utilize district transportation when traveling to and from school-sponsored events outside of the Golden Triangle. Only under emergency circumstances will the Transportation by Non-District Sponsored Driver request be approved.

NON-SPONSORED TRANSPORTATION

The undersigned hereby acknowledges and understands that the Anderson Union High School District does NOT provide transportation to the school-sponsored activities inside the Golden Triangle and that it is the responsibility of the undersigned to arrange for transportation. Student-Athletes may not drive other students to and/or from athletic events. As parent/legal guardian, I hereby authorize and give permission for my child to drive himself/herself or to ride as a passenger in a vehicle driven by another parent.

The undersigned acknowledges and understands that the driver is not driving on behalf of or as an agent of the Anderson Union High School District. Further, the undersigned understands that the Anderson Union High School District has not verified the driving record of the driver or the mechanical condition of the vehicle.

IT IS FULLY UNDERSTOOD THAT THE ANDERSON UNION HIGH SCHOOL DISTRICT IS IN NO WAY RESPONSIBLE, NOR DOES THE ANDERSON UNION HIGH SCHOOL DISTRICT ASSUME LIABILITY, FOR ANY INJURIES OR LOSSES RESULTING FROM THIS NON-DISTRICT SPONSORED TRANSPORTATION. ALTHOUGH THE ANDERSON UNION HIGH SCHOOL DISTRICT MAY ASSIST IN COORDINATING THE TRANSPORTATION AND/OR RECOMMEND TRAVEL TIME, ROUTES, OR CARAVANNING TO OR FROM THIS EVENT, I FULLY UNDERSTAND THAT SUCH RECOMMENDATIONS ARE NOT MANDATORY.



Outside of the Golden Triangle: Any exceptions to transportation guidelines will be made when the parent contacts the principal or designee in advance (by note or call) of the activity. In these cases the student-athlete will be released to the parent/guardian by the person in charge, upon direct authorization by the principal or designee.

Student Signature

Date

Parent/Guardian Signature

Date

TRANSPORTATION BY NON-DISTRICT SPONSORED DRIVER (Emergency use only)

I understand the Anderson Union High School District provides transportation to and from the school-sponsored activities outside of the Golden Triangle. However, I do not wish to avail myself of the transportation provided by the district. My student, _____, hereby requests permission to ride with a non-district sponsored driver (who may or may not be the parent of the student).

IF THE STUDENT IS TRANSPORTED BY A NON-DISTRICT SPONSORED DRIVER (WHO MAY OR MAY NOT BE THE STUDENT'S PARENT), IT IS FULLY UNDERSTOOD THAT THE DISTRICT IS IN NO WAY RESPONSIBLE, NOR DOES THE DISTRICT ASSUME LIABILITY, FOR ANY INJURIES OR LOSSES RESULTING FROM THIS NONDISTRICT SPONSORED TRANSPORTATION. ALTHOUGH THE DISTRICT MAY ASSIST IN COORDINATING TRANSPORTATION AND/OR RECOMMEND TRAVEL TIME, ROUTES, OR CARAVANNING TO OR FROM THIS EVENT. I FULLY UNDERSTAND THAT SUCH RECOMMENDATIONS ARE NOT MANDATORY.

I ALSO UNDERSTAND THAT BY RIDING WITH THE NON-DISTRICT SPONSORED DRIVER; THE DRIVER IS NOT DRIVING AS AN AGENT OF OR ON BEHALF OF THE DISTRICT.

Student Signature

Date

Parent/Guardian Signature

Date

AUHSD ATHLETIC POLICY ACKNOWLEDGMENT

The undersigned fully understands that all extracurricular activity participants are governed by the policies, regulations, and standards contained within the Parent/Student Handbook. Policies listed below can be found at www.auhsd.net or picked up in your school's main office.



By initialing each item, you acknowledge that you have read, understand, and agree to comply with the policies listed:

ACKNOWLEDGEMENT OF ATHLETIC POLICIES & INFORMATION

All Athletic Policies in the Parent/Student Handbook, including but not limited to:	Parent/Guardian Initials	Student Initials
High School Athletic Code	_____	_____
Student Athlete Code of Conduct	_____	_____
Student Athlete Tobacco, Alcohol, & Drug Policy	_____	_____
Ethics in Sports	_____	_____
NCAA Initial Eligibility Clearinghouse	_____	_____
Authorization to Use School Transportation	_____	_____
Use of Steroids	_____	_____
Required Student-Athlete Health & Safety Fact Sheets		
Concussion & Head Injury Information	_____	_____
Sudden Cardiac Arrest (SCA) Information	_____	_____
Opioid Use & Misuse Fact Sheet	_____	_____
Heat Illness Prevention Information	_____	_____

I understand fully that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by the Anderson Union High School District Board of Trustees and the sponsors for the activity in which I participate.

I also authorize the Anderson Union High School District to conduct a test on a urine specimen which I provide to test for drugs and/or alcohol use. I also authorize the release of information concerning the results of such a test to the Anderson Union High School District and to the parents and/or guardians of the student.

This shall be deemed a consent pursuant to the Family Education Right to Privacy Act for the release of the above information to the parties named above. I also authorize the use of names and photographs to be published on the District athletic web site.

Student Name (please print)

Student Signature

Date

Parent/Guardian Signature

Date

You're almost at the finish line — see next page.

HEALTH HISTORY – To be completed and signed by parent/guardian

Student Name _____ Phone Number _____

9 10 11 12 _____ **M F**

Grade (circle) _____ Date of Birth _____ Sex (circle) _____

Has your child ever had or currently have any of the following?

- | | | | |
|--------------------------|--------------------------|---|-------------------------|
| Yes | No | | If yes, please explain: |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic or recurrent illnesses | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Illnesses lasting more than a week | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery, other than tonsillectomy | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Problem with blood pressure or heart | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, fainting, or frequent headaches | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ever been knocked out or had concussion | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck/back injury or surgery | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee injury or surgery | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle injury or surgery | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other joint sprains or dislocations | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken bones or fractures | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ missing, other than tonsils | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or seizure disorder | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or shortness of breath | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat exhaustion or heat stroke | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous disorder or mental illness | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently taking medication (aspirin, penicillin, etc.) | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy to medication (aspirin, penicillin, etc.) | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of eye glasses or contact lenses | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of dental appliances | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Family history of death before age 50 | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Any reason student should not participate in sports | _____ |

Date of last tetanus vaccination: _____

I declare that the above information is correct to the best of my knowledge. I understand this is a screening examination to determine if any obvious medical problems exist to prevent my child from participating in school athletic events. This examination is not a complete medical examination. You should contact your family physician for your medical needs. If any medical problems are identified in this screening examination, further examination and treatment should be obtained through your physician. Please discuss family medical history with your student.

Parent/Guardian Signature _____ Student Signature _____

ATHLETIC HEALTH SCREENING EXAMINATION RECORD

HEALTH SCREENING EXAMINATION – To be completed and signed by a physician

Height: _____ Weight: _____

Pulse Rate: _____ Blood Pressure: _____

Eye Exam: **R:** 20/____ **L:** 20/____ **Both:** 20/____

	Normal	Abnormal	Comments
Mouth/Pharynx			
Heart			
Lungs			
Abdomen			
Genitalia (male only)			
Spine			
Joints			
Extremities			

Based on this history and physical exam, the following abnormalities were found and may need treatment:

RECOMMENDATION

- There were no history or physical findings in this exam which would prohibit this student from participating in competitive athletics.
- This student should have the above health problems evaluated or treated PRIOR to participating in competitive athletics.
- This student has health problems which would PROHIBIT him or her from participating in competitive athletics at this time.

Physician Signature _____ Physician Stamp _____ Date _____