

**ALPINE SCHOOL DISTRICT**

Consent and Authorization Form

Name of Participant \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent's Business Phone \_\_\_\_\_

**CONSENT TO PARTICIPATE**

I give my consent for the above named student to participate in the following activity of Alpine School District:

\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR MEDICAL TREATMENT**

I authorize \_\_\_\_\_ or any other school supervisor involved in the above named activity, as my agent(s) to consent to any necessary emergency medical or dental treatment. This authorization shall remain effective until \_\_\_\_\_

Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or legal Guardian

**MEDICAL INFORMATION TO BE USED AS NECESSARY**

Health and Accident insurance in force (Company) \_\_\_\_\_

Do you have or require any of the following:

Special Diet?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Allergies?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Chronic or recurring illness?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Medication?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Physical Condition that would limit activity?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has the student had surgery or a serious illness in the past year?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If the answer is yes to any of the above, give full particulars of each. (Use the back of this form if necessary)  
Please supply any other information which should be known by the supervising teacher.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_