

COLUMBIA ELEMENTARY SCHOOL MEDICAL PERMISSION SLIP

Student's Name _____ DOB _____ Age _____

Parent/Guardian of student's name _____ Relationship _____

Best contact number _____ 2nd contact number _____

Student's address _____ City and Zip _____

Family Physician or Health advisor _____

Hospital _____ Additional Information _____

Please list two local people to be reached when family members are unavailable:

Name/Phone: _____ Relationship: _____

Name/Phone: _____ Relationship: _____

Your Medical Insurance Provider and Policy Number must be provided before a student will be allowed to participate on a sports team:

I have health or accidental insurance for my child which meets the requirements of California Law and elect not to purchase student insurance

Medical Insurance: _____ **Policy Number:** _____

I have sent a check for student accident insurance as indicated below in order to meet the requirements of the California Las. Please check one:

_____ School Time Insurance (covers sports other than football) **Policy Number:** _____

_____ Full Time Insurance (covers sports other than football) **Policy Number:** _____

I have completed the above Permission Slip and given Columbia School District, in my absence, permission to have my child transported to the hospital of my choice (indicated above) in the event of illness or injury. I also hereby grant them permission to sign for treatment of my child at said hospital.

Signature of Parent/Guardian: _____ Date: _____