OFFICIAL MERCED COMMUNITY COLLEGE DISTRICT FORM

MEDICAL TREATMENT AUTHORIZATION

RISK MANAGEMENT/#2706/REVISED, JANUARY 2017

PARTICIPATION IN CLASS/ACTIVITY – MEDICAL TREATMENT AUTHORIZATION

Participant's Name (*Print Legibly*): _____ **Student ID#**: _____

In consideration of being permitted to participate in any way in:
Name of class/activity:

_____

Description of class/activities; IE: hiking on nature trail, walking tour of museum, sledding, skating, etc

_____

scheduled on _____ ,

I understand that the class/activity, by its very nature, includes certain risks and could cause minor injury, major injury, and serious injury, including permanent disability and death. In the event of illness or injury, **I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, emergency transportation, and hospital care considered necessary** in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

I further acknowledge that the District does not provide liability or medical insurance coverage for participants who participate in this class/activity.

☐ I have no special health needs the staff should be aware of, and no medication is required during this class/activity.

☐ I have a special need, and instructions are attached. Number of attached pages: _____.

☐ Other: _____

Medical Insurance Carrier: _____ Policy Number: _____
(e.g., Blue Cross)

In the event of an emergency, please contact:

_____ _____ Work: (____) _____
Name Relationship Home: (____) _____
Cell: (____) _____

_____ _____ _____ _____
Signature of Participant Date Signature of Parent/Guardian Date
(If participant is under age 18)