

**PALOS VERDES PENINSULA UNIFIED SCHOOL DISTRICT  
 MEDICAL TREATMENT AUTHORIZATION  
 WAIVER, RELEASE AND INDEMNITY AGREEMENT  
ASSUMPTION OF RISK FOR PARTICIPATION IN A VOLUNTARY SPORTS OR NON-SPORTS PROGRAM**

WAIVER: (1) parent uses his/her own vehicle and drives their own student;

Participant: \_\_\_\_\_

(2) student uses his/her own vehicle to drive him/herself only for voluntary sports or non-sports program.

Description of Activity: \_\_\_\_\_ Name of School: PV Peninsula HS

Date(s) of Activity: 2018-2019 School Year

Transportation provided by District       Transportation is parent responsibility

By my signature below, I hereby give permission for my son/daughter to participate in the above-described activity. I realize that this activity is voluntary as part of the PALOS VERDES PENINSULA UNIFIED SCHOOL DISTRICT (District) sports or non-sports program. I understand that this activity could cause serious illness and/or injury or death, and I assume all risks for any such illness and/or injury or death. I am aware of the transportation arrangements for this activity and acknowledge that if the school is providing no transportation, the parent has complete and sole responsibility for all transportation arrangements. I am aware that the District does not provide coverage for medical treatment in connection with this activity. If a participant does not have private medical insurance, low-cost school insurance is available through the District.

For and in consideration of permitting the above named child to participate in the activity described above, the undersigned hereby voluntarily releases, discharges, waives and relinquishes any and all actions or causes of action for personal injury, bodily injury, property damage or wrongful death occurring to his/her child/ward or him/herself arising in any way whatsoever as a result of engaging in said activity or any activities incidental thereto wherever or however the same may occur and for whatever period said activities may continue. The undersigned does for him/herself, his/her heirs, executors, administrators and assigns hereby release, waive discharge and relinquish any action or causes of action, aforesaid, which may hereafter arise for him/herself and for his/her estate, and agrees that under no circumstances will he/she or his/her heirs, executors, administrators and assigns prosecute, present any claim for personal injury, bodily injury, property damage or wrongful death against the District or any of its officers, agents, or employees for any of said causes of action, whether the same shall arise by the negligence of any of said persons, or otherwise.

The undersigned hereby acknowledges that he/she knowingly and voluntarily assumes all risks of bodily injury to his/her child/ward or him/herself, as stated, and expressly acknowledges their intention, by executing this instrument, to exempt and relieve the District, its officers, agents, and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way be connected with the above-described activity. I have read and understand the foregoing and have voluntarily signed this agreement. I am aware of the potential risks involved in this activity and I am fully aware of the legal consequences of signing this instrument. I further acknowledge that the District does not automatically provide for medical coverage for participants in this activity.

Health or special needs: Check as appropriate.

	Participant has no special health needs the staff should be aware of, and no medication is required.
	Participant has a special need, and instructions are attached. Number of attached pages: _____.
	Other: _____

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation 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.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (Please Print)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Health Plan

\_\_\_\_\_  
Street Address      City      State      Zip Code

Plan # \_\_\_\_\_