

ADULT STUDENT HEALTH DATA and Medical Authorization

For School Year: 2011-2012

Name of Class: Santa Cruz Parent Education Nursery School Section Number: _____

Teacher's Name: _____

Adult Student's Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____
Street City State Zip Code

Cell Phone: _____

Medical Insurance Carrier: _____

Policy Number: _____

Physician's Name: _____ Physician's Phone Number: _____

Please list any special medical conditions or medications: _____

Check here if there are **no** special problems or required medications that the staff should be aware of.

In the event of illness or injury, please notify: _____
Name Address Phone

Please notify the teacher if any of this information changes during the school year.

As stated in California Education Code Section 35330, I understand that I hold the Santa Cruz City Schools District, its officers, agents and employees harmless from any and all liability or claims arising out of or in connection with my participation in the activities of this program.

In the event of any illness or injury, I hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care from a licensed physician and /or surgeon as deemed necessary for my safety and welfare. It is understood that the resulting expenses will be the responsibility of the participant.

Signature: _____ Date: _____