ADULT VOLUNTEER PARTICIPATION IN VOLUNTARY ACTIVITY

HOLD HARMLESS AND MEDICAL TREATMENT AUTHORIZATION

Name:_____Date_____

Nature of Activity: _____
(Please be specific, e.g. basketball, fundraising,.)

As a condition of my participation in this Fullerton School District activity, I acknowledge that the District does not provide any type of insurance including liability, property, or medical coverage for any death, bodily injury, personal injury, or illness, or any loss to property sustained during the course of my involvement in the above listed activity. I further acknowledge that this activity could cause illness and/or injury.

In the event of illness or injury, I do hereby consent to whatever x-rays examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation considered necessary in the best judgement 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 agree to waive all claims against the Fullerton School District and to indemnify and hold the District, its officers, agents, and employees, harmless from any and all liability or claims, demands, losses, cause of action, suits or judgements of any kind whatsoever that I, my heirs, executors, administrators or assignees may have against the District or that any other person or entity may have against the District because of any death, bodily injury, personal injury, or illness, or because of any loss to property that may arise out of or in any way be connected with the above-described activity. This waiver shall not apply to any occurrences that may arise solely out of the negligence of the District, its employees or agents.

- ☐ I have no special health needs the staff should be aware of and no medication is required during this activity
- ☐ I have consulted with my physician and verify that I am medically fit to participate in this activity.

_____ _____
Signature Date

_____ Work ( ) _____
Address: Number Street

Home ( ) _____

_____
City State Zip Code

Health Insurance Company: _____ Policy Number: _____
(e.g., Blue Cross)

In the event of illness or accident, please notify:

Name:_____ Relationship: _____

_____ Work Phone ( ) _____
Address: Number Street

_____ Home Phone ( )_____
City State Zip Code