EL CAPITAN HIGH SCHOOL ATHLETIC CLEARANCE CARD

ID Number _____ Grade _____ Sport _____

Student Name: _____

Address: _____

City: _____ ZIP: _____ Phone: _____

Parent/Guardian Name: _____ Work/Cell Phone: _____

Emergency Contact: _____ Phone: _____ Work/Cell Phone: _____

Doctor's Name: _____ Phone: _____ Hospital Choice: _____

Medicine Allergies? (Please list): _____ List any medications currently taking: _____

INSURANCE: I hereby declare that my student (named above), has medical insurance in the amount of at least $1500.00 administered by _____ Insurance Co., Policy # (required) _____, which will provide coverage for medical and hospital expenses resulting from accidental bodily injury while practicing for or participating in interscholastic athletic events **OR** subscribes to the required insurance coverate specified through the insurance carrier approved by and made available through the Grossmont Union HS District.

I ACCEPT FULL RESPONSIBILITY TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGE OR LAPSE IN THE ABOVE POLICIES.

In case of an emergency and if parent/guardian and above medical doctor cannot be reached, permission is given to school authorities to seek emergency medical treatment at a hospital or medical facility.

Parent/Legal Guardian Signature: _____ **Date:** _____