SIERRA JOINT COMMUNITY COLLEGE DISTRICT
PARTICIPATION IN A HIGH RISK CLASS/ACTIVITY
PERMISSION, ASSUMPTION OF RISK, HOLD HARMLESS &
MEDICAL TREATMENT AUTHORIZATION

Check One: _____ Required Curriculum Activity _____ Voluntary Activity

Student's/Volunteer's Name: _____ hereby requests permission to participate in

the following college class/activity:_____

I understand that this class/activity could cause serious illness and/or injury, and I assume all risks for any such illness and/or injury. 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.

Because of the dangers of participating in this class/activity, I recognize the importance of following instructions regarding proper technique, training and other established safety rules, guidelines and regulations. I agree to abide by all rules and regulations governing this class/activity.

As a condition of my participation in this class/activity, I agree to waive all claims against Sierra Joint Community College District (District) and to indemnify and hold District, its officers, agents, and employees, harmless from any and all liability or claims, demands, losses, causes of action, suits or judgments 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 further acknowledge that the District does not provide liability or medical insurance coverage for participants who participate in this 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 ( ) _____

_____ _____ _____
Student's/Volunteer's Signature Name – Please Print Date

If Student/Volunteer is under the age of 18:

_____ _____ _____
Parent/Guardian - Signature Parent/Guardian Name – Print Date

RM:sh 004 (10/01/05)