



**WESTERN PLACER
UNIFIED SCHOOL DISTRICT**

600 SIXTH STREET, SUITE 400
LINCOLN CA 95648
916.645.6350 FAX 916.6445.6356

**Participation of District Volunteer
Assumption of Risk and Medical Treatment Authorization**

Name: _____ Today's Date: _____

Date You Will Volunteer: _____ Times: _____

School Site You will Volunteer at: _____

Purpose of Your Volunteering: _____

Method of Transportation (if applicable):

School Bus Personal Vehicle Walk Other: _____

I HEREBY WAIVE ALL CLAIMS AGAINST THE DISTRICT AND ITS BOARD, EMPLOYEES OR AGENTS FOR INJURY, ACCIDENT, ILLNESS, OR DEATH OCCURRING DURING OR BY REASON OF THE FIELD TRIP OR EXCURSION. (CALIFORNIA EDUCATION CODE 35330 AND 5 CCR 55220).

In the event of illness or injury, I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis 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: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Health Insurance Company: _____ Policy #: _____

In the event of illness or accident, please notify:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

If there are any special medication instructions, kindly attach an explanation to this sheet and check appropriate box: Instructions attached No instructions attached