

RIPON POLICE ACTIVITIES LEAGUE
259 N. Wilma Ave.
Ripon, CA 95366

PARENT AUTHORIZATION:

Child's Name _____ Date of Birth: _____ Age: _____

The above named child has my Permission to participate in activities conducted by the Ripon Police Activities League and I understand my permission will remain in effect until I withdraw it. The undersigned does hereby release and discharge the Ripon Police Activities League, all its agents, employees and officers thereof of and from all actions, causes of action, damages, claims and demands, in law or in equity, of every kind and character, including claims resulting in any injury by way of damages, either civil or criminal, we or either of us have or our successors, assigns, heirs, executors or administrators may hereinafter have against them, or any of them, which might arise in connection with the above named acting in the capacity of a participant of a program or otherwise using equipment or facilities provided by the Ripon Police Activities League or injury which may hereafter be sustained by reason of such participant or equipment and all claims arising out of same, whether known or unknown, suspected or unsuspected.

As the parent or legal guardian of the above-named participant, I hereby give my consent for emergency care prescribed by a duly licensed doctor of medicine. This care may be given -under whatever conditions is necessary to preserve the life, limb, or well being of my dependent.

IN WITNESS WHEREOF, the undersigned have hereunto set their hand this

_____ day of _____ 2005

Signature of Parent/Guardian

Printed name of Parent/Guardian

Witness Signature

Printed name of Witness

RIPON POLICE ACTIVITIES LEAGUE

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Ripon, Ca 95366

HEALTH HISTORY & PERMISSION SLIP:

Child's Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Emergency Contact Person: _____

Telephone #: _____

Health/Accident Insurance Company: _____

Policy No: _____

Please circle if your child has or has had:

Asthma

Fainting Spells

Convulsions

Heart Trouble

Diabetes

Bleeding Disorders

Please explain any yes answers:

Check here if none of the above applies _____

Have difficulty with (circle if yes)

Eyes

Ears

Nose

Throat

Digestion

Lungs

Bed Wetting

Sleep Walking

Any condition now requiring regular medications?

Yes No

If yes, please list names of medication:

Does your child have any restriction of activity for medical reasons? Yes No

If yes, please explain:

Are your child's immunizations up to date? (Check if yes)

Tetanus Toxoid _____ Diphtheria _____ Polio _____

Mumps _____ Rubella _____ Measles _____