CULVER CITY UNIFIED SCHOOL DISTRICT
ADULT VOLUNTEER PARTICIPATION IN VOLUNTARY ACTIVITY
HOLD HARMLESS AND MEDICAL TREATMENT AUTHORIZATION

Date: _____

Name: _____ hereby requests participation in the following activity:

_____

(Description of activity; please be specific)

I understand that this activity could cause serious illness and/or injury. In the event of illness of injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation 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.

As a condition of my participation as a Culver City Unified School District (District) volunteer in this activity, I acknowledge that the District does not provide property or medical coverage for volunteers for any death, bodily injury, personal injury, or illness, or insurance to cover any loss to property sustained during my course as a District volunteer. I agree to waive all claims against Culver City Unified School 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 employee 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 Name (Please Print)

Family Medical
Insurance Carrier: _____ Policy Number: _____
(e.g. Blue Cross, Kaiser, etc)

In the event of an emergency, please contact:

_____ _____

Name (Please Print) Relationship

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Original – Mary Soto, Business Services
Copy – Volunteer Site File

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