SFUSD ATHLETIC OFFICE
VOLUNTARY ACTIVITY PARTICIPATION FORM
ACKNOWLEDGMENT AND ASSUMPTION OF POTENTIAL RISK

____________________________ wishes to participate in the District-sponsored activities
of____________________________.

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious
injury/illness to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses which may result from participating in
these activities include, but are not limited to, the following:

1. Sprains/strains
2. Fractured bones
3. Unconsciousness
4. Head and/or back injuries
5. Paralysis
6. Loss of eyesight
7. Communicable diseases
8. Death

I understand and acknowledge that participation in these activities is completely voluntary and as such is
not required by the District.

I understand and acknowledge that in order to participate in these activities, I agree to assume liability and
responsibility for any and all potential risks which may be associated with participation in such activities.

I understand, acknowledge, and agree that the District, its employees, officers, agents, or volunteers shall
not be liable for any injury/illness suffered by me which is incident to and/or associated with preparing for
and/or participating in this activity.

If the student has health or accident insurance, list company name, policy number and local claims address:

____________________ ______________________ _______________________
Company Name  Policy #    Claims Address

____________________ ______________________ _______________________
Family Doctor’s Name  Phone #    Preferred Hospital – in case
of emergency

I acknowledge that I have carefully read this VOLUNTARY ACTIVITIES PARTICIPATION FORM
and that I understand and agree to its terms.

I hereby give my consent for my son/daughter to compete in the sport(s) of ________________________.
In case of illness or injury, the head coach or site administrator is authorized to have the student examined
and treated, and authorize the medical agency to render treatment. I also consent to permit access to the
contents of this form and my son/daughter’s physical examination form to licensed physicians engaged in
providing medical services to student-athlete participants.

_____________________________________________ _________________________
Student Signature      Date

_____________________________________________ _________________________
Parent/Guardian Signature     Date