Holy Names High School

Sports Clinic Permission Form

(BRING THIS FORM COMPLETED to Volleyball clinic check-in on July 28, 2025)

To the Principal of Holy Names High School:

I, the parent/guardian of _____

hereby request that the school allow my daughter to participate in the conditioning Volleyball Clinic

_____

LOCATION:	**Holy Names High School, 4660 Harbord Drive, Oakland, CA 94618**
WHEN:	**July 28 - July 31, 2025**
PICKUP/DROPOFF :	**Both pickup and drop off are on Harbord Drive (front of school)**
TIME:	**3:30pm - 5:00pm (Campus closes at 5:15 pm)**

In consideration for the making of the arrangements for this clinic, I hereby release, hold harmless and indemnify Holy Names High School and all its employees from any and all claims, including loss, theft or damage to personal property of my daughter as a result of this clinic. I further agree that in the event that my daughter is injured arising out of her participation in this sports clinic through the negligence of the school or any of its employees or volunteers, I waive, release, hold harmless and indemnify Holy Names High School, its employees and volunteers.

I direct my daughter to cooperate and conform with instructions and directions of the supervisory school personnel in charge of this sports clinic. I acknowledge that all school rules and penalties for their infractions are in effect during the entire time of this clinic. In the event of a serious infraction by my daughter of school regulations or special regulations given by school supervisory personnel for this clinic and it is deemed necessary by the school supervisor to send my daughter home as a result of this infraction, I acknowledge that I will be called by the school supervisor in charge and agree that it is my responsibility to arrange for my daughter to be transported home at my expense.

CONSENT FOR MEDICAL TREATMENT

Should it be necessary for my daughter to have medical treatment while participating in this clinic, I hereby give permission to the school representation of Holy Names High School to authorize, by his/her signature, whatever medical or surgical treatment may be considered necessary or advisable by the physician, nurse or emergency medical technician in attendance. I am aware and agree, payment of all hospital, medical or related costs and expenses will be the direct responsibility of myself, and covered under our current accident/medical insurance or any available benefit plan of mine or my spouse (guardian/ex-spouse, etc.).

Parent/Guardian Signature _____ Date _____

Address _____

Home Phone # _____ Work/Cell Phone # _____

Student Cell Phone # _____

Health Benefit Company Name and Type of Plan _____

Alternate Contact in Case of Emergency _____
(Name) (Phone)

Allergies, Reactions, or Medical Concerns: _____

Inhaler /other Medications: _____