

BAND STUDENT'S MEDICAL RELEASE FORM

Date _____ Name _____ Grade _____

Date of birth _____ Age _____ Social Security Number _____

Address _____ Home phone number _____

Mother's Name _____ Work Number _____ Cell _____

Father's Name _____ Work Number _____ Cell _____

Emergency #'s 1st call _____

2nd call _____

3rd call _____

HEALTH INFORMATION:

Allergies: Medicine _____ Bees _____ Ants _____ Food/other _____

Medical conditions (circle if you have the following):

Asthma _____ Diabetes _____ Pump _____ injection(s) _____ pills _____

Epilepsy (seizures) _____ bleeding disease _____ Surgeries: _____

Eye problem(s) _____ Ear problem(s) _____ Nose bleeds _____ other: _____

List any medication that student takes on a regular basis _____

We may only give medication that you have provided in original bottle. You have filled out a form, and doctor for this medication. I give permission to have my child treated by the medical designate on band trip(s), band camp, or performances. I understand that all reasonable precaution will be taken for my child's safety, and I will not hold the school or designate responsible for any illness or unforeseen accident.

I, the undersigned, do hereby authorize the official/health care designate of St. Clair County schools to contact directly the person(s) named on this paper, to render such treatment as may be deemed necessary in an emergency for the health of my child. In the event physician(s), or other person(s) named on this paper, or parents are unable to be reached, I give permission to transport my child to the nearest medical facility. **Every** attempt will be made to reach the parent/guardian or emergency person listed above.

I, the undersigned do also hereby give my permission for my child to travel with the _____ Band to their designation, games, events, etc. I will not hold the high school, band, or St. Clair County School System responsible for any accident, etc.

Signature of Parent/Guardian _____

Child's Doctor _____ Doctor's address _____

Insurance Company _____ Insurance number _____

Hospital of choice _____