

FIELD TRIP PERMIT/MEDICAL HISTORY AND RELEASE

I, _____, the parent and/or legal guardian of _____, a minor, give my permission for him/her to travel with the West Mesquite High School "Burnt Orange Band" and director(s), Scott Patricia, Lacy Brown, Michael Gibson and Amy Mayes for all required performances, including, but not limited to, all football games, marching competitions, and off-campus concerts for the duration of the 2015-2016 school year. Bus transportation will be provided for students to and from most performances.

I release the school, the school district, and its personnel of any and all liabilities. In the event there arises an emergency requiring medical attention for my child, I do hereby authorize that treatment be given by qualified and licensed medical personnel. I understand I will be notified as quickly as possible and that all expenses incurred in treatment will be assumed by my insurance or by me. Should medical attention be needed, I hereby authorize the sponsor to administer aid until said qualified medical personnel arrive.

Signature (Parent and/or Guardian)

Home Phone #

Work Phone #

Cell Phone #

MEDICAL INFORMATION

I, _____ of _____,
Name Address City State Zip

give my consent for the transfer to any hospital reasonably accessible, and consent to release the medical information provided.

Band Member's Signature Date _____

Parent/Guardian's Signature Date _____

The following information is needed by any hospital or practitioner not having access to the member's medical history. :

Does the member have (Any items marked "Yes" should be explained below):

- | | | |
|---|-----|----|
| 1. Existing health conditions? | Yes | No |
| 2. Any allergies | Yes | No |
| Food | Yes | No |
| Medication | Yes | No |
| Other (bee stings, etc.) | Yes | No |
| 3. Any health problems or physical disabilities | Yes | No |
| 4. Any respiratory problems | Yes | No |
| 5. Any diabetes | Yes | No |
| 6. Any epilepsy | Yes | No |
| 7. Any chronic disease | Yes | No |
| 8. Any emotional or psychological problems | Yes | No |
| 9. Any medication being taken at present | Yes | No |
| 10. Any Glasses | Yes | No |
| Contact Lenses | Yes | No |
| Hearing Devices | Yes | No |

If any of the above questions are marked "YES", please explain. **If taking medication, please give name, dosage, and time medication is taken.**

Date of last tetanus booster: _____
Month Day Year

Does student have all required immunization shots? _____ Yes _____ No

Name of Medical Insurance Carrier, Policy #/Group #, and the name of the Insured (primary holder of policy)