CHS BANDS - Medical Release Form

Parental Consent for Medical Treatment

PLEASE RETURN TO A DIRECTOR BY: BAND CAMP

I, the undersigned parent, legal next-of-kin, or legal guardian of _____, hereby authorize any necessary medical treatment for this person during the time in which he/she is participating in the **Clinton High School Band program**. I also guarantee payment of all charges incurred during the course of said medical treatment (physician, hospital, X-ray, lab, medication, ambulance, etc.)

In regard to such person, I submit the following information:

1. Allergies to food, medication, etc. (if none, please state it so)

_____
_____
_____

2. Special medical problems (if none, please state it so)

_____
_____
_____

3. Does the participant carry or require medications? (if none, please state it so)

Medication: _____ Purpose:_____
Medication: _____ Purpose:_____
Medication: _____ Purpose:_____

4. Date of last Tetanus shot:_____
5. Family Physician: _____
   Office Address: _____
   Phone Number: _____

Parent/Guardian Signature _____

Printed Name: _____

Relationship to Participant: _____

Address:_____

Home Phone:_____

Daytime Phone:_____

Cell Phone: _____

***IMPORTANT – Students may NOT participate in any outside the school day band activities or trips without this form turned in.**