GRANT BANDS

MEDICAL RELEASE and

PERMISSION FORM

2017

Student _____Gender M F (circle) Grade_____

Addressv_____ T-shirt size _____

City _____State_____ Zip_____ Date Of Birth_____

EMERGENCY PHONE NUMBERS (Please print legibly)

	Name	Day	Night	Cell
Father/ Guardian				
Mother/ Guardian				
Emergency Contact				
Emergency Contact				

MEDICAL INSURANCE INFORMATION (please keep updated)

Insurance Company _____

Policy # _____Group # _____

ID # _____OTHER# _____

PERMISSION

I give _____ permission to participate in all activities of the Grant High School Band as approved by the school administration and the Grant Public Schools Board of Education during the 2017-2018 school year. I give the Band Director and/or authorized chaperones and/or certified medical personnel authority to seek and/or render medical aid for my child in the event of an illness or injury. I understand that at least one person listed above is to be contacted should the listed child become ill or injured.

Parent / Guardian _____Date _____

The medical information provided on the back of this form is confidential. It will only be viewed by volunteers providing first aid, paramedics or emergency physician.

EMERGENCY MEDICAL INFORMATION Student name _____

(Please print legibly)

ALLERGIES (Fill in or write NONE)

_____

_____

_____

MEDICATION STUDENT IS NOW TAKING (Prescription, Non-prescription, or NONE - include dosage information)

_____

_____

_____

CHRONIC HEALTH PROBLEMS / CONCERNS (Fill in or write NONE)

_____

_____

_____

SPECIAL NEEDS (Fill in diabetic supplies, inhaler, etc., or NONE)

_____

_____

_____

DIETARY RESTRICTIONS (Fill in or write NONE)

_____

_____

_____

While with the band, my child may take the following common over-the-counter medicines according to recommended dosages, if he/she requests: (Check approved medicines)

__ Acetaminophen (Tylenol)

__ Ibuprofen (Advil)

__ Naproxen Sodium (Aleve)

__ Benadryl

__ Sudafed

__ Tums

__ Lozenges for sore throat

__ Other

__ **My child should not take any of these medications.**

Parent / Guardian _____ Date_____