W. P. DAVIDSON HIGH SCHOOL BAND
MEDICAL INFORMATION AND CONSENT FORM

This form MUST be signed before a Notary Public and returned prior to July 31, 2009

Student Name ______________________ Home Phone ____-____-____

Address ______________________ City ____________ Zip ________

Parent/Guardian #1 ______________________ Parent/Guardian #2 ______________________

#1 Home Phone # ____________ Work # ____________ Cell # ____________

#2 Home Phone # ____________ Work # ____________ Cell # ____________

IN CASE OF EMERGENCY: Name and phone number of person to notify if you cannot be reached:

Name ______________________ Phone: ____-____-____ Relationship: ________

HEALTH INFORMATION

Is the student subject to any of the following or has any other significant health problems of which the Director or chaperons should be aware? (Check all that apply)

☐ Asthma ☐ Heart Disease ☐ Seizure Disorders ☐ Diabetes ☐ High Blood Pressure ☐ Bleeding Disorders

☐ Other: ______________________

Is the student allergic to any medications, foods, or insect toxins? ☐ YES ☐ NO

If so, please list the specific medications, foods, or insects: ______________________

____

Please list all medications this student is taking: ______________________

____

Can this student swim? ☐ YES ☐ NO

If swimming activities are involved, does this student have permission to participate? ☐ YES ☐ NO

Is this student subject to motion sickness during travel? ☐ YES ☐ NO

STUDENTS ARE RESPONSIBLE FOR TAKING THEIR OWN MEDICATION AT THE PROPER TIME AND IN THE PROPER DOSAGE. CHAPERONS WILL NOT ADMINISTER MEDICATIOINS.

INSURANCE INFORMATION (*please include a copy of insurance card front and back*

CARRIER ______________________ POLICY # ______________________

GROUP NUMBER ______________________ PHYSICIANS'S CHART # ______________________

PHYSICIAN ______________________ PHONE # ______________________

over

IF ***NO*** **INSURANCE**, PLEASE COMPLETE THE FOLLOWING:

FOR AND IN CONSIDERATION OF EMERGENCY SERVICES AND GOODS RENDERED BY OR THROUGH THE ATTENDING PHYSICIAN (S) THE UNDERSIGNED GUARANTEES PAYMENT IN FULL, IMMEDIATELY UPON RECEIPT OF FINAL BILLING.

SIGNATURE OF GUARDIAN____

PRINT NAME______________________________ DATE____________________

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, being parent, legal guardian, or next of kin of

Student ______________________________ Date of Birth______________

Hereby grant authorization to Davidson H.S. Band Directors and/or chaperons of Davidson High School Band Boosters Assoc, standing in loco parentis, to obtain emergency medical and/or surgical treatment and procedures from a physician or hospital emergency room on behalf of the above named minor. I also give permission to administer over the counter medication if necessary.

SIGNATURE ______________________________ RELATIONSHIP____________________

Subscribed and sworn to before me on ______________________________.

____

NOTARY PUBLIC

My Commission Expires________________

PERMISSION FORM

I have read the letter and rehearsal/performance schedule of the Davidson H.S. Band summer and fall activities, and understand my obligation as a band member.

Signed (student)____

I give permission for (student)______________________________ to attend all events with the Davidson High School Band Program. I have read the attached rules and regulations concerning my student's behavior, and understand that failure to follow rules will result in disciplinary action. I waive any liability of the school or Davidson High School Band Boosters Assoc for injury or damage sustained by my student or his possessions during trips.

Parent's Signature______________________________ Date____________________