

MENENDEZ HIGH SCHOOL BAND MEDICAL INFORMATION & RELEASE FORM (Please Print Clearly)

Student Name: Last _____ First _____ Middle _____

Address _____
(Street) (City/State) (Zip)

Home Phone # _____ Date of Birth _____ Student's Grade This Year _____

In Case of Emergency, Call: _____ Phone # _____ Relationship _____

Are you covered by medical insurance: (circle) Yes No

Name of Insurance Company _____ Policy ID# _____ Phone _____

Contact Prior to Medical Treatment: (circle) Yes No

Name of policyholder: _____

Are you covered by Medicare/Medicaid: (circle) Yes No If yes, Policy ID#: _____

A COPY OF THE MEDICAL INSURANCE CARD IS REQUIRED!

PARTICIPATION CONSENT AND AUTHORIZATION FOR TRAVEL & MEDICAL CARE

IMPORTANT NOTICE: Although participation in the Menendez Band programs does not involve the type of physical contact and high level of risk as participation in school sports program, it is important to acknowledge the possibility that you may become ill or injured while participating in travel or other related Band activities.

Band members can and have the responsibilities to help reduce the chance of injury. Band members must obey all safety rules, report all physical problems to their Director, and conduct themselves in a manner consistent with the Code of Discipline for the St. Johns County School System while participating in the Band related activities.

By signing this permission form, you acknowledge that you have read and understand the above notice. Any adult/parent/guardians who did not wish to accept the risks and responsibilities described in this notice should not sign this permission form.

(1) I, _____ HEREBY GIVE MY CONSENT FOR MY CHILD TO PARTICIPATE IN THE MENENDEZ BAND PROGRAM.

(2) TO ACCOMPANY THE BAND ON SCHEDULED TRIPS DURING THE 2009/2010 SCHOOL YEAR.

(3) IN CASE OF EMERGENCY OR ACCIDENT ON THE SCHOOL GROUNDS OR DURING ANY SCHOOL ACTIVITY, WHICH IN THE OPINION OF SCHOOL AUTHORITIES PRESENT (Including, but not limited to Band, Color Guard Instructors, or Staff/Clinicians) REQUIRES IMMEDIATE MEDICAL OR SURGICAL ATTENTION, I HEREBY GRANT PERMISSION TO SAID SCHOOL AUTHORITIES TO OBTAIN THE SERVICE OF A PHYSICIAN OR TO TRANSPORT SAID STUDENT TO THE HOSPITAL IF IT IS DEEMED NECESSARY BY SCHOOL AUTHORITIES, I HEREBY GRANT SAID PHYSICIANS PERMISSION TO TREAT CONDITION UNLESS I REQUEST OTHERWISE.

MEDICAL HISTORY/CURRENT TREATMENTS

Do you have any chronic on ongoing illnesses, such as asthma, heart condition, diabetics, etc? (circle) Yes No

If yes, please list _____

Do you take any medicines regularly? (circle) Yes No If yes, name medicine(s) _____

Name/Phone # of Doctor _____

Are you allergic to any drugs or medications? (circle) Yes No

If yes, list: _____ Date of last tetanus shot: _____

Do you have any restrictions on activities for medical reasons: (circle) Yes No

If yes, explain: _____

Please list any past serious injuries, illnesses or operations and estimated dates or any special medical treatment instructions for you based on personal medical history, religious or cultural practices: _____

I have read and understand the above notice and verify that the information on this form is correct.

SIGNATURE OF ADULT/PARENT/GUARDIAN: _____ Date _____

Relation to Child: _____