

Medical Release/Travel/Acknowledgment

This form is used as both a Travel release and Medical Emergency ("Consent to Treatment of a minor") Form. This form is recommended by the Missouri State High School Activities Association for use by all students who participate in educational trips and activities. It is required that this form be on file in the band office prior to any student being permitted to travel with the Parkview High School Band. This form will be with the director on all trips. Please provide very accurate information.

Students Name _____ Date of Birth ____ / ____ / ____

Parent/Guardian Name: _____

Home Phone: () _____ Work Phone () _____ / () _____
Father Mother

1st Emergency Contact: _____ Phone () _____

2nd Emergency Contact _____ Phone () _____

Does this student have school insurance? Yes _____ No _____ Type _____

Guardian Insurance _____

Company _____ Policy # _____

Family Physician: _____ Phone () _____

Military Dependant? Yes _____ No _____ Military I.D # _____

Allergies: _____

Medication Allergies: Penicillin _____ Sulfa _____ Others: _____

Please list any medical conditions that are important in the care of the aforementioned student in the event of necessary medical attention. (Asthma, diabetes, allergies, heart conditions, etc.)

Please list all medication currently being taken either by prescription or "over the counter".

Students sign below indicating an understanding of the goals and policies of the Parkview High School Band and indicating their desire to participate in this musical group. Failure to conform to the band, school, and or district policies may result in disciplinary actions and/or dismissal from the band program.

Student Signature: _____ Date: ____ / ____ / ____

I, the parent/guardian, of the above student have read and understand all of the rules, commitments, and policies of the Parkview Band Program and give my consent that the above mentioned student may participate in the events required of the band program. I also give my consent for emergency medical treatment if needed while on R-12 District sponsored activities

Parent/ Guardian Signature: _____