

STUDENT/ADULT PERMISSION & MEDICAL RELEASE FORM

Consent to Travel

I, _____, give permission for _____,
(parent or guardian) (name of participant)

to travel with the East Aurora High School Band to Sandusky, Ohio.

The group will depart on October 26th, 2018 and return on October 28th, 2018.

In the case of an emergency, please contact _____
(emergency contact and relation to participant)

at _____ or _____.
(phone number) (second phone number)

Consent to Receive Treatment

As parent or guardian of _____,
(name of student)

I authorize treatment of the above mentioned student by a qualified physician or nurse in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual, trained in first aid, if in the opinion of that individual, delay might endanger his/her life, cause disfigurement or undue comfort. On the Medical Information Form I have listed any allergies, ongoing medical treatment, or medical problems which might influence treatment of the student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the understanding that except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

Contact Information

Authorized Signature

Date

Address

Home Phone

MEDICAL INFORMATION FORM

Student's Name _____
(First) (Middle) (Last)

Home Address _____
(Street)

City _____ State _____ Zip _____

Home Telephone Number _____
(Area code) + (Number)

Cell Phone Number _____
(Area code) + (Number)

Student's date of birth _____

Religion (optional) _____

Medical problems or allergies which might influence medical treatment (If none, please state "none known").

If student is under physician's care for ongoing medical treatment, please complete the following:

Medication(s) _____

Condition _____

Physician's Name _____ Physician's Telephone Number _____

Insurance Information

Name of Primary Insured _____

Primary Insured's Employer _____

Insurance Provider _____

Group Number _____ Member Number _____

*****Please copy insurance card and card holders ID on the back of this form or attach to this sheet.**