DECATUR CENTRAL HIGH SCHOOL BANDS

Student Medical Release Form

LAST NAME ____________________

DATE OF BIRTH: ____________________

I hereby consent for a qualified physician or surgeon to examine, diagnose, prescribe and perform treatment including surgery that is deemed advisable for the welfare of:

STUDENT'S FULL NAME ____

I give my permission for the above named student to take recommended dosage of:

☐ Tylenol (Acetaminophen) ☐ Advil (Ibuprofen) ☐ Pepto Bismol ☐ Tums/Rolaids

☐ Midol ☐ Imodium A-D ☐ Benadryl

Please list any medical concerns and/or medications the student currently takes: ______________________

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List any known allergies:

Medications ____

Food ____

Environmental ____

Date of Last Tetanus Inoculation: ____

Are Immunization Vaccines Up to Date: ☐ YES ☐ NO

INSURANCE COMPANY ____

GROUP NUMBER ______________________ MEMBER ID. NUMBER ______________________

PERSONAL PHYSICIAN______________________ PHYSICIAN'S PHONE ______________________

I hereby give my consent for the Director(s), Band Booster(s), or any designee of the Decatur Central High School Band to render medical care as deemed necessary to preserve the life, limb, or well-being of the above named student. I will not hold Decatur Central High School, Band Director (s), Band Booster, Inc., affiliates, designees or anyone involved liable for any situation beyond their control. I agree to pay all costs incurred by the participant(s) for the hospital bills, physician fees and ambulance fee.

I understand that I will be contacted by someone in authority at the time my child is admitted to the hospital and/or treated by a physician.

PARENT/GUARDIAN SIGNATURE ______________________ DATE:______________________

RELATIONSHIP TO STUDENT______________________

Emergency Contact Numbers:

Parent Primary Contact: ______________________

Parent Cell 1: ______________________

Parent Secondary Contact: ______________________

Parent Cell 2: ______________________

Additional Emergency Contact: ______________________ Contact #:______________________