



DECATUR CENTRAL HIGH SCHOOL BANDS
Student Medical Release Form



DATE OF BIRTH:

LAST NAME

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/Roloids
Midol Imodium A-D Benadryl

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

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 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 Secondary Contact:

Parent Cell 1: Parent Cell 2:

Additional Emergency Contact: Contact #: