MEDICAL RELEASE/PERMISSION FORM

I/We give permission for my/our student____to participate in CE BANDS 2021/2022. I/We realize that my/our student may sustain injuries that may require medical attention. Therefore, I/we authorize the Band Director to secure any necessary medical treatment for my/our student. I/We do not hold the Band Director, Murphysboro District #186, or any of its representatives responsiblefor any medical treatment rendered because of injuries sustained.

MEDICAL INFORMATION

Member's Name____

Member's Social Security Number___________________________________Date of Birth________________________

Parent/Guardian Name____

Parent/Guardian Social Security Number____

Home Address____

Street City State Zip

Home Telephone Number____

Insurance Provider____Policy Number________________________

Family Physician____Telephone Number_____________________

Emergency Contact____Telephone Number_____________________

Relationship to Student____

On the reverse side of this form, please list any and all medications the member is presently taking OR isallergic to that might be pertinent if he/she may need medical treatment. Please be detailed and specific.

On the reverse side of this form, please list any specific food allergies that could cause medical issues for yourchild or any special dietary needs.

NOTARY

This instrument was acknowledged before me on ____

By: ____

____ ____

Parent/Guardian Signature Notary Signature