ATHENS HIGH SCHOOL BAND MEDICAL RELEASE FORM

Student's Name: (print) _____Sex _____ Age _____ Date of Birth _____

Street Address _____ City/Zip _____

Home Phone _____ Cell Phone _____

Father _____ Mother _____

Father's Work Phone _____ Mother's Work Phone _____

Father's Cell Phone _____ Mother's Cell Phone _____

Alternate Adult Name _____ Phone _____

Doctor's Name _____ Phone _____

TO BE COMPLETED BY A PARENT OR GUARDIAN

Health Information: Circle any health conditions that apply:

Asthma	Diabetes	Frequent Nosebleeds	Heart Disease	Ear Problems
Cerebral Palsy	Epilepsy	Headaches/Migraines	Hernia	High Blood Pressure

Other Health Problems (please list): _____

_____

_____

List allergies to food, medications, other (If none, so state): _____

_____

Is student taking medication regularly? _____
If yes, please specify medication
and condition requiring such medication: _____

_____

If you choose to allow an adult administer the following medications indicate below by circling the following medications:

Tylenol Aspirin Motrin Advil None

Insurance Provider: _____ Policy Number: _____

The above named student has my permission to participate in school-sanctioned activities as a member of the Athens High School Band. Students, even when off campus, are still subject to school rules and regulations when participating with the Band.

By signing this document, the parent and/or legal guardian releases the Athens Independent School District and the Athens High School Band directors, chaperones, volunteers, etc. from any and all claims resulting from the injury of the above named student or the loss of property of the above named student while participating in any activities connected with the Band. In the event that the above named student requires medical treatment deemed necessary by first aid or emergency medical personnel, and the above named contacts cannot be reached, I the parent/legal guardian of the above named student, do hereby authorize the Directors/Chaperones to be consulted with, and consent to, any medical treatment deemed necessary by a doctor, nurse, or other medical personnel. I also guarantee payment of all charges incurred for the treatment.

_____ _____

Parent/Legal Guardian Signature Date