

PLEASE TURN IN BY 1ST DAY OF BAND CAMP
2016-2017 | Student Medical Information

Print Please

Student's full name _____

Parent's name _____

Home Phone _____ Business Phone _____

Students Local Doctor _____ Drs. Phone number _____

Health Insurance Company and policy number:

List any medications your child takes on a regular basis:

List any medications to which your child is allergic:

List any allergies or other conditions a doctor would need to be aware of in an emergency:

I understand that my child will be expected to follow the instructions of the directors and chaperones and that he will be responsible for following the school and band rules at all times. I also understand the policy forbidding the use or possession of alcohol, tobacco, or other drugs and the seriousness with which such an infraction will be regarded. Any damage to hotel property will be the responsibility of the student involved and his parents.

Parents signature _____ Date _____

I give my permission for doctors or other medical personnel to administer treatment to:

(Student's name) _____ in case of an emergency.

Parents signature _____ Date _____