



## MEDICAL RELEASE/PERMISSION FORM

I/We give permission for my/our student \_\_\_\_\_ to participate in CE BANDS 2022/2023. 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 responsible for 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 is allergic 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 your child or any special dietary needs.

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**NOTARY**  
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This instrument was acknowledged before me on \_\_\_\_\_

By: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Notary Signature