West Harrison High School Band Medical Release Form

Student's Full Name:_____

Social Security Number:_____ DOB:_____

Student's Address (No PO Box)_____

_____

_____

Student's Primary Physician:_____

Physician's Phone:_____

Any known medical conditions:_____

_____

_____

List any allergies:_____

_____

_____

Date of last Tetanus Booster:_____

Is the student taking any prescription medications? _____No _____Yes (please list)

_____

_____

_____

Insurance Company:_____

Policy Number:_____

Name of Insured:_____

Relationship to student if different from the student:_____

Primary emergency Contact Information:

Primary contact:_____

Relationship to student:_____

Phone Number:_____ Secondary Phone Number:_____

Secondary contact:_____

Relationship to student:_____

Phone Number:_____ Secondary Phone Number:_____

Permission for medical treatment:

I give my permission as parent/legal guardian of_____to allow the staff of the West Harrison High School Band to provide information and seek medical treatment for my child in the event that I am not present.

Parent/Guardian Name (Please Print)_____

Parent/Guardian Signature:_____ Date:_____

Notary Signature:_____

Commision Expires:_____

THIS FORM MUST BE RETURNED BEFORE YOUR STUDENT IS ALLOWED TO TRAVEL WITH THE WHHS BAND.