

MEDICAL FORM

STUDENT'S NAME _____ BIRTH DATE _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____ PHONE _____

FATHER'S NAME _____ BUSINESS PHONE _____

MOTHER'S NAME _____ EMERGENCY PHONE _____

_____ HAS PERMISSION TO TRAVEL WITH THE MORRISTOWN-HAMBLÉN HIGH SCHOOL EAST BAND. HE/SHE WILL BE UNDER THE DIRECT SUPERVISION OF THE BAND DIRECTOR. EVERY EFFORT WILL BE MADE TO ENSURE THE SAFETY OF THE STUDENT.

DATE _____ SIGNATURE OF PARENT _____

PLEASE LIST ANY MEDICAL INFORMATION WE SHOULD KNOW ABOUT YOUR CHILD. INCLUDE ALL ALLERGIES. _____

LIST MEDICATIONS YOUR CHILD IS TAKING. (YOU ARE RESPONSIBLE FOR NOTIFICATION OF CHANGES IN MEDICATION.) _____

DESCRIBE ANY PROBLEMS OR CONCERNS YOU MAY HAVE ABOUT YOUR CHILD. _____

HEALTH/MEDICAL INSURANCE _____
(COMPANY) (POLICY NUMBER)

I HEREBY GIVE PERMISSION FOR THE ABOVE NAMED CHILD TO RECEIVE MEDICAL TREATMENT FROM ANY LICENSED PHYSICIAN AND/OR HOSPITAL. THEY ARE HEREBY AUTHORIZED TO PROVIDE MEDICAL TREATMENT DEEMED NECESSARY FOR THE SAFETY AND WELL BEING OF MY CHILD. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL MEDICAL COSTS INCURRED AS A RESULT OF MEDICAL TREATMENT FOR MY CHILD.

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

SWORN AND SUBSCRIBED TO ME THIS _____

DAY OF _____ 20____. MY COMMISSION

EXPIRES _____.

NOTARY PUBLIC