

BELLE VERNON AREA HIGH SCHOOL MARCHING BAND

MEDICAL FORM

(Please fill out and hand in ASAP)

(Must be handed in at band camp, otherwise student will not be permitted to participate)

Name: _____ Instrument: _____

Address: _____ Grade: _____ HR: _____

_____ Birthdate: _____

Parent/Guardian's Name(s): _____

Home Phone: _____ Work Phone: _____

Work Phone (2): _____ Cell Phone: _____

Name of two (2) responsible people to be contacted in an emergency (MUST be WORKING TELEPHONE NUMBERS!!)

1. _____ Phone: _____

2. _____ Phone: _____

Family Doctor: _____ Phone: _____

Medical Insurance Co. Name: _____

Group #: _____ Agreement #: _____

Plan Code: _____

Illness: _____

Allergies: _____

Current Medications: _____

Does this student wear contact lenses? Yes or No (Circle one)

If yes, what type? _____

I understand this activity involves somewhat strenuous physical exertion and feel that my son/daughter is physically fit for such activities. In any situation where "superficial first aid" is not sufficient, trained medical personnel WILL be summoned. When possible, contact will be made with the parent/guardian or other responsible person before treatment occurs. Transport will be made to the nearest hospital. These decisions will be made at the discretion of the Director and/or Staff, who are not likely to take any risks with the welfare of your children. I hereby grant permission for my son/daughter to participate with the Belle Vernon Marching Band in all scheduled activities. I further grant permission for my son/daughter to receive emergency medical treatment, as required, during any organized music activity, if I cannot be contacted in advance.

Parent/Guardian Signature: _____ Date: _____