

This form is confidential and will be retained in a secure location by the Head Chaperone during travel.

Cleveland High School Band Parent's Association, Inc. Medical Treatment Permission Form

I the undersigned, being the parent, legal guardian, or legal next-of-kin of the student, hereby authorize any necessary medical care by medical professionals for this person while participating in activities sponsored by the Cleveland High School Band Parent's Association. Over the counter medications may be administered as deemed necessary. I also guarantee payment of all charges incurred during the treatment (ambulance, physician, hospital, x-ray, laboratory, medications, etc.). In regard to such person, I submit the following pertinent information:

Student's Name:	Student's DOB:
Student's Grade:	Marching Instrument: Concert Instrument:
Mailing Address:	City, State, Zip:
Students Home Phone:	Student's Cell Phone:
Mother's Name:	Mom's Cell Phone: Mom's Work Phone:
Father's Name:	Dad's Cell Phone: Dad's Work Phone:
Allergies (medication, food, etc)	
Special medical needs	
Current medications (including vitamins)	
Date of last tetanus shot	
Physician name and phone	
Medical Insurance: Provider Subscriber's Name Policy Number	

We will **always** attempt to contact the parent/guardian first. Please provide two alternate emergency contacts (not parents) we can contact for your student(s).

Emergency Contact (Primary):	Relationship:
Phone (cell/work/home):	Alt Phone (cell/work/home):
Emergency Contact (Secondary):	Relationship:
Phone (cell/work/home):	Alt Phone (cell/work/home):

SIGNATURE OF PARENT OR LEGAL GUARDIAN (REQUIRED):

(SEAL)

Signature Date Relationship