

**MJHS Band Boosters, Inc. Medical Form/Field Trip Consent 2023-24**

***You must complete two notarized copies of this form & include 2 copies of ins. Card, Front & Back***

**Student Contact Information**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**Parent/Guardian Contact Information**

Mother/Guardian Full Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Father/Guardian Full Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Emergency Contact Information** *Please list someone other than parent, local contact only* Emergency contact name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship to student: (relative, neighbor, friend, etc.): \_\_\_\_\_

**Student Medical Information** *Must be complete before student may participate in band camp*

Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Date of last Tetanus Shot: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Does student have any known allergies? Yes / No If yes, list: \_\_\_\_\_

Circle any of the following that may apply to your child:

Heart Disease High Blood Pressure Diabetes Asthma Seizures Bronchitis Diabetes Contacts/Glasses Braces **Any other information concerning your child’s medical conditions may be explained on the reverse side of this form.**

- I/We hereby voluntarily consent to my child traveling with Mt. Juliet High School Band of Gold to offsite performances and competitions.
- I/We hereby voluntarily consent to the rendering of such care, including diagnostic procedures and surgical or medical treatment by authorized members of the hospital staff or their designees.
- I/We acknowledge that no guarantees have been made to me/us as to the effect of such examination or treatment on the child’s condition.
- I/We give consent to Mt. Juliet High School Band Director(s) and Chaperones who will be caring for my/our child **May 5, 2023- May 31, 2024**, to arrange for emergency medical/dental care and treatment necessary to preserve the health of my/our child.
- I/We accept responsibility for all reasonable charges in connection with care and treatment rendered during this period.

Name of Insurance Carrier: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

To the best of my/our knowledge, all information presented here is complete and accurate:

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State of: \_\_\_\_\_ County of: \_\_\_\_\_

Signed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2022;

Signature of notary public \_\_\_\_\_ Printed Name of notary public \_\_\_\_\_

My commission expires: \_\_\_\_\_

## Additional First Aid Treatment Consent

**Student Name:** \_\_\_\_\_

The First Aid volunteers need permission to administer over the counter medications for the conditions listed below.

**Heat related stress** Electrolytes – sport drink, sunscreen, ice packs

**Minor Wound** Topical antibiotics such as triple antibiotic ointment and Bacitracin (Abrasions)

**Foreign objects in the eye** Eye flush aids

If you do **NOT** wish to have particular medications administered to your child, please indicate which ones below:

\_\_\_\_\_  
\_\_\_\_\_

**Other Medical Information you think we should be aware of:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*I hereby give authorized designees of the MJHS Band Program permission to seek medical attention for the child listed on this form.*

**Parent/Guardian Full Name:** \_\_\_\_\_ **Parent/Guardian**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/2023