MJHS Band Boosters, Inc. Medical Form/Field Trip Consent 2024-25

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 3rd, 2024- May 31, 2025**, 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 _____, 20___;

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: **____/___/ 2024**