____

(Student's Last Name) *please print* (Student's First Name)

I agree to release the Southington Board of Education, Southington Band Backer's and assigned chaperones from any responsibility for injuries incurred by my son/daughter during band trips.

Should an emergency situation arise, I hereby give permission to the Band Director to obtain proper medical aid, including hospitalization, for my son/daughter. I will assume responsibility for all costs relating to such medical attention. Parent/Guardian(s) will be notified as soon as possible. I also authorize the Band Director or assigned member of Band Backers to provide transportation for my son/daughter for the Medical facility or Paramedic following an emergency in my absence.

My Family is covered by the following medical insurance:

______________________________ ______________________________

Insurance Carrier Membership Number/Policy Number

Policy Holders Name: ____

Subscriber (Employer): ____

Where Parents Can Be Reached In An Emergency:

____

Home Address Home Telephone

____

Father's Place of Business Mother's Place of Business

____

Father's Business Address Mother's Business Address

____

Father's Business Tel. Number /Cell Mother's Business Tel. Number/Cell

My son/daughter is authorized to take the following medications, as prescribed by a physician. (All medication must be carried in the prescription bottle as obtained from the pharmacy with a label that clearly identifies the contents. Unmarked pillboxes or bottles will not be allowed.)

Please list only those medications that are taken on a regular basis.
PLEASE LIST MEDICATIONS:

______________________________ ______________________________

Pharmacy Physician

Prescriptions (medications):____

My son/daughter does NOT take medications (Check if applicable) ______________

My son/daughter is allergic to the following medications:

____

Please list any other pertinent health data you feel would help us in the event of a medical emergency (i.e. past history, injuries, etc.). Check any if applicable and explain if necessary.

_____Back Problems _____Diabetes _____Other (explain)______________

_____Scoliosis _____Cardiac

_____Epilepsy _____Asthma

Band Member's Name: ____

Street Address: ____

City, State, Zip Code: ____

Parent Signature: ______________________________ Date: ______________________