



2010 - 2011

# CONFIDENTIAL MEDICAL INFORMATION RELEASE FORM FOR CO-CURRICULAR ACTIVITY

This form MUST be completed and signed by the student's parent/guardian to be valid. This form gives consent for any approved PHSMB staff/chaperone to secure emergency services (medical, dental, paramedic, ambulance) for the student at the parent/guardian's expense. Efforts will be made to contact the parent/guardian prior to treatment or hospitalization.

| CONTACT INFORMATION - PLEASE PRINT CLEARLY  |                              |  |
|---|------------------------------|--|
| STUDENT NAME:   |                              | STUDENT HOME ADDRESS:                    |
| GRADE (Fall '10):   | CITY:                        | ZIP:                                     |
| GENDER:   | BIRTH DATE:                  | MAILING ADDRESS (IF DIFFERENT THAN HOME) |
| INSTRUMENT:   | CITY:                        | ZIP:                                     |
| HOME PHONE:   | PARENT'S NAMES:              |  |
| STUDENT'S CELL:   | Mother:                      | Father:                                  |
| STUDENT'S EMAIL:  | PARENT'S CELL PHONE NUMBERS: |  |
| MUSIC PROGRAM: _____<br>(Orchestra, Marching Band, Color Guard, or Non-Marching Band) | Mother:                      | Father:                                  |
|   | PARENT'S EMAIL ADDRESSES:    |  |
|   | Mother:                      | Father:                                  |

  

| EMERGENCY (NON-PARENT / GUARDIAN) CONTACTS |                         |              |
|--|-------------------------|--------------|
| FIRST PERSON TO CONTACT - NAME:            | RELATIONSHIP TO STUDENT | PHONE NUMBER |
| SECOND PERSON TO CONTACT - NAME:           | RELATIONSHIP TO STUDENT | PHONE NUMBER |

Information helpful to a physician in case of emergency and information school staff / chaperones need to be aware of for the student's safety. The parent/guardian is responsible for ensuring this information is updated.

**Medical problems** (i.e. Diabetes, Asthma, Seizures): \_\_\_\_\_

Usual symptoms: \_\_\_\_\_

\*Care OR medication needed: \_\_\_\_\_

**Allergies** (i.e. food, bee stings, medication): \_\_\_\_\_

Usual symptoms: \_\_\_\_\_

\*Care OR medication needed: \_\_\_\_\_

Is the student currently under medical care? Yes \_\_\_ No \_\_\_ (Explain) \_\_\_\_\_

Are there any other factors that may affect the care of your student? (If yes, be specific) \_\_\_\_\_

**\*If medication(s) are required, please fill out Form B with Physician Signature.**

**I UNDERSTAND THAT BY SIGNING THIS FORM:**

I give permission for staff/chaperones to provide first aid care and secure emergency care at my expense if needed.

I release the Poway Unified School District, its officers, employees, agents or Poway High School Music Boosters and chaperones from any and all liability, loss, expense or claim for illness, injury or damages that may arise from participation in the Poway High School Music Program or any associated activity. Further, I understand that the District does not provide accident/medical insurance for students and that I am expected to provide such insurance coverage.

\_\_\_\_\_  
SIGNATURE OF PARENT / GUARDIAN & DATE

\_\_\_\_\_  
INSURANCE COMPANY

\_\_\_\_\_  
POLICY/GROUP NUMBER