

MEDICAL INFORMATION

WESTERN WAYNE HIGH SCHOOL MUSIC DEPARTMENT

I hereby give permission for _____ to participate in the Western Wayne Band for the 2024-2025 school year.

EMERGENCY INFORMATION

STUDENT NAME: _____

ADDRESS: _____

PARENT OR LEGAL GUARDIAN: _____

ADDRESS: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

OTHER CONTACT: _____

RELATIONSHIP: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

STUDENTS REGULAR PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

Please list any medical conditions or allergies and symptoms associated with same for the above mentioned student.

Please list any medications the student is currently taking. Use additional sheets if needed.

Date of student's last tetanus shot: _____

Food Allergies/Preferences (i.e. gluten free, no dairy, etc) _____

Medication Permission

In the event of need, my child may be administered:

	YES	NO
Acetaminophen		
Ibuprofen		
Antacid		

MEDICAL INSURANCE

Company: _____

Identification Number of Plan: _____

Name of Covered Person: _____

Identification Number of Covered Person: _____

Signature of Medical Insurance Subscriber: _____

MEDICAL TREATMENT AUTHORIZATION

I, _____ certify and understand that in the event of an accident or illness to my child, the Band Director, another staff member, or Chaperone, will try to notify me or my emergency contact person. In the event of medical emergency concerning my child where I or my assigned contact cannot be reached, I authorize the Band Director, or other authorized chaperone to secure services as deemed necessary by qualified personnel of a licensed medical doctor and/or hospital. I further agree that I will incur the expenses for necessary services in the event of accident or illness and provide for the payment of these costs.

Parent / Guardian Signature: _____

Date _____