Pearl High School Band
Medical Release Authorization

Band Student/Member Name: ____

If your child needs medical care, dental care or hospital services, you as parent/guardian must give permission. IT IS THE LAW! In an emergency, your child can only be treated without your consent if a physician determines that your child's life or health is at risk. Unless a true emergency exists, medical personnel are powerless to help your child without your authorization. That is why you must complete this Medical Treatment Authorization form. You can prepare for the unexpected by giving other adults permission to authorize necessary treatment for your child during your absence. By filling out the form you may legally appoint anyone over 18 years of age-relatives, teachers, babysitters, and friends to take this responsibility. Complete this form carefully, and have your signature witnessed by a Notary Public. The original must be on file before your child is allowed to participate in the Pearl Band Program.

I, _______________________________, Legal Parent/Guardian of _________________________ authorize:
(Parent/Guardian Name) (Student Name)

Name: Matt Rowan, Director of Bands, Pearl High School

Name: Nicole Allen, Assoc. Director of Bands, Pearl High School

Name: Aimee Sudduth, Asst. Band Director, Pearl High School

Name: Matt Little, Asst. Band Director, Pearl High School

Name: Jason Harrell, Asst. Band Director, Pearl High School

To act on my/our behalf in authorizing unexpected medical, dental, surgical care or appropriate hospital representatives at such times as unexpected medical, dental, surgical care or hospitalization may be required.

Parent Guardian:______________________________
(PLEASE PRINT)

Signature: ___________________________________

Address:______________________________________

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Date:_________________________________

Parent Guardian:______________________________
(PLEASE PRINT)

Signature: ___________________________________

Address:______________________________________

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Date:_________________________________

INSURANCE COVERAGE FOR ABOVE NAMED MINOR:

Insurance Program Name:_______________________________

ID or Contract Number:________________________________

NOTARY PUBLIC:

The above parent(s)/Guardian(s) personally appeared before me on: ____________________________

Notary Signature:___________________________ My Commission Expires:__________________________

(Affix Seal or Stamp Here)

Band Member Name:___________________________ Date of Birth:_________________________

Drug Allergies:

____ No known Drug Allergies

Family Physician Name:_______________________

Allergic to: ______________________________

Physician Phone Number: _____________________

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Medications:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Reason Taken:

1.
2.
3.
4.
5.
6.
7.
8.
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10.

Medical History:

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Surgical History:

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Special Needs:

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