

MOUNTAIN VIEW HIGH SCHOOL BANDS MEDICAL INFORMATION / PARENT CONSENT

Please complete this entire form – do not leave any blank spaces

**** WE MUST HAVE A COPY OF YOUR INSURANCE CARD TO KEEP ON FILE WITH THIS FORM ****

Student's Last Name: _____ First: _____ Middle: _____

Address: _____ City _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Information:

Father's Name: _____ Mother's Name: _____

Father's Work: _____ Mother's Work: _____

Work Phone: (_____) _____ Work Phone: (_____) _____

Emergency Contact Name (required): _____ Phone: _____

Family Doctor's Name: _____ Phone _____

Dentist/Orthodontist: _____ Phone: _____

List any known health problems and/or physical restrictions (If none, please write "None"): _____

List any known allergies (If none, please write "None") _____

List any current medication ** (If none, please write "None"): _____

**Students taking medications on a regular basis are required by SCPS regulations to turn in these medications to be held in a security box on any extended trip. A complete list of the student's medications and when they are to be taken *must* be included. Medications must be in the original prescription container. Students will be able to take their medications as needed. Students must also have medications listed on file with the school nurse's office.

The band parents/chaperones have my permission to administer the following to my child for minor pain:

____ Ibuprofen (Advil, Motrin)

____ Acetaminophen (Tylenol)

Parent Signature: _____

Parental Consent:

I am familiar with my child's wishes to participate in the marching band at Mountain View High School. I am aware that taking part in this activity carries the risk of injury to my child, particularly due to travel and the physical aspects of rehearsal and performance. The Director of Bands, professional band staff and/or band parents/chaperones have my permission, in an emergency situation when I (or my physician) cannot be contacted, to seek medical assistance at a medical clinic or hospital emergency room at my expense. Further, the medical clinic or hospital personnel have my authorization to provide emergency treatment deemed necessary by a physician for the well being of my child. I certify that I have adequate insurance coverage as stated below and I accept full responsibility for any medical expenses arising due to the injury or illness of my child while participating as a member of the band.

Signature of Parent/Guardian: _____ **Date:** _____

Printed Name of Policy Holder: _____

Insurance Company: _____ Policy Number: _____ Group Number: _____

This form must be notarized:

Commonwealth of Virginia, City/County of _____

The foregoing instrument was acknowledged before me this

_____ day of _____, 20_____

by: _____

(name of person seeking acknowledgment)

Notary Public

My Commission Expires: _____

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