

WALTER M. WILLIAMS HIGH SCHOOL MARCHING BAND

Medical / Liability Release Form

PLEASE PRINT CLEARLY

Student _____

Address _____

City / State / Zip _____ Home Phone _____

Student's Date of Birth _____ Instrument _____

Fathers Name _____ Mothers Name _____

Father's Day Phone _____ Mother's Day Phone _____

Father's Cell _____ Mother's Cell _____

Alternate Adult Name _____ Phone _____

Student E-Mail Address _____

Parent E-Mail Address _____

Name of Family Physician _____

Address _____

Telephone _____

Name of Family Dentist _____

Address _____

Telephone _____

Insurance Company _____

Policy Number _____ Group Number _____

Name of Parent who is the Policy Holder _____

The above named student has my permission to participate in school-sanctioned activities as a member of the Walter M. Williams High School Band during the 2016-2017 school year. Students, even when off campus, are still subject to the school rules and regulations when participating with the Marching Bulldogs. I understand that any student who does not conduct themselves properly may be (1) sent home at the parent's expense; (2) prohibited from future activities of this organization and/or (3) subject to other appropriate disciplinary action.

By signing this document, the parent and/or legal guardian releases the Alamance-Burlington School System and the Walter M. Williams band directors, instructors, chaperones, volunteers, ect. from any and all claims resulting from the injury of the above named student or loss of property of the above named student while participating in any activity connected with Walter M. Williams Band.

In the event that the above named student is presented for, or requires medical treatment or surgery or any other form of medical care or aid, I, parent/legal guardian of the above named student, do hereby authorize the Director / Chaperones to consult with, and consent to, any medical treatment or care deemed necessary by any doctor, nurse or other medical personnel. I also guarantee payment of all charges incurred for medical treatment such as, but not limited to physician, hospital, x-ray, lab, drugs, EMS.

This form must be signed and returned to the Walter M. Williams Band Director before the will be allowed to participate in any off campus activity.

Signature of Parent / Guardian

Date

Place an (X) in front of any of the following illnesses you have had:

- | | | | |
|--|---|--|-----------------------------------|
| <input type="checkbox"/> ECZEMA | <input type="checkbox"/> MEASLES | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HIVES |
| <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> NERVOUS EXHAUSTION | <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> MUMPS |
| <input type="checkbox"/> TONSILLITIS | <input type="checkbox"/> DIVERTICULITIS | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> POLIO | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HERNIA |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> ASTHMA | | |

Any other serious illnesses or operations you have had:

Please list any medications you may be taking with dosage, schedule, reason for administration, and possible side effects of the medication:

Date of last tetanus shot: _____

Do you wear corrective lenses or contacts: _____

Additional medical information or comments:

Date: _____ Signature of Parent/Guardian: _____