

# Murphy High School Band Medical Release 2023-2024

## SECTION I: Student Personal Information

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Cell phone \_\_\_\_\_

### Parents/Guardians

Parent 1 \_\_\_\_\_ Phone (Cell) \_\_\_\_\_ (W) \_\_\_\_\_  
Parent 1's email \_\_\_\_\_ Parent 2's email \_\_\_\_\_  
Parent 2 \_\_\_\_\_ Phone (Cell) \_\_\_\_\_ (W) \_\_\_\_\_

If persons named above are not available in the event of an emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name of personal physician \_\_\_\_\_ Phone \_\_\_\_\_  
Personal health/accident insurance carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of insured \_\_\_\_\_ Relationship \_\_\_\_\_

**Please attach a copy of your Health Insurance Card to this form.**

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## SECTION II. Health information

Allergies	Yes _____ No _____	Explain _____
Asthma	Yes _____ No _____	Diabetes Yes _____ No _____
Cancer/Leukemia	Yes _____ No _____	Heart trouble Yes _____ No _____
Seizures	Yes _____ No _____	Other _____

Routine Medications \_\_\_\_\_

Do you wear contact lenses Yes \_\_\_\_\_ No \_\_\_\_\_

Do we have permission to give your child over-the-counter medications? Yes \_\_\_\_\_ No \_\_\_\_\_

**If there are any special instructions or concerns about your child's health that we need to know about while traveling with your child, please note these instructions or concerns on the back of this form.**

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## SECTION III: Authorization/Hold Harmless

In the event of an emergency, I \_\_\_\_\_ give Mr. Alex White, or his representative, permission to obtain any necessary emergency medical care for my child \_\_\_\_\_ while participating in Murphy H.S. Band activities. I understand that every effort will be made to contact me in the event of an emergency. I also agree to assume responsibility for all expenses that occur due to the medical treatment of my child.

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_