

**FLOWER MOUND HIGH SCHOOL BAND GENERAL AND
MEDICAL RELEASE FORM**

I, the undersigned, for the purpose of enabling _____
a minor, to participate in *ALL FLOWER MOUND HIGH SCHOOL BAND ACTIVITIES AND TRIPS DURING THE 2010-2011 SCHOOL YEAR*, do hereby release and authorize the Flower Mound High School Band Boosters Club, representatives or agents as follows:

1. You are hereby released from any and all liability or claims present or future, known or unknown, of every kind, character or description that may be created by or arising out of, either directly or indirectly, said school function.
2. In the event of accident, injury or illness requiring medical attention, you are specifically authorized and given sole discretion to obtain such medical attention at such place and from such person or persons as your sole judgment shall determine necessary.

I have read this release and understand its terms. I execute voluntarily with full knowledge of its significance, and with the intention of binding myself.

Parent(s) Signature: _____ Date: _____

Contact Information

Print Student's Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Father's Name _____ Day Phone: _____

Evening Phone: _____ Cell Phone: _____

Mother's Name: _____ Day Phone: _____

Evening Phone: _____ Cell Phone: _____

Insurance Company: Name: _____

Group # _____ Policy # _____

Phone # _____

Medical Information

Medication Allergies: _____ or circle **None**

Food Allergies: _____ or circle **None**

Ongoing Medications w/dosage: _____

Medical History: _____

Family Physician/Pediatrician:

Physician's phone number: _____

Medication Administration

I hereby authorize the FMHS Band Medic staff, physician, hospital or school representative to provide immediate care and treatment of any injury or sickness. I further authorize the Medic staff to administer to my child over-the-counter medications as needed during FMHS band activities 2010-2011. This list includes Ibuprofen Acetaminophen, oral or topical Benadryl, Claritin, Cough or Throat lozenges Tums, Immodium, etc.

Parent/ Guardian Signature: _____

Date: _____

I do NOT wish for my child to receive any medications by Medic staff.

Parent/ Guardian Signature: _____

Date: _____

**~ PLEASE NOTE: NO STUDENT WILL BE ALLOWED TO PARTICIPATE IN
MARCHING BAND WITHOUT THIS FORM ON FILE~**