

WALTON BAND AND ORCHESTRA PARENTS, INC.

MEDICAL INFORMATION, PERMISSION AND RELEASE FORM

Student Name:		Home Phone:		Circle one:	
Last: _____ First: _____				Male Female	
DOB:		Grade:			
Mother's Name:	Home #:	Work #:	Cell #:		
Father's Name:	Home #:	Work #:	Cell #:		
Alternate Contact:	Relationship:	Home #:	Cell #:		
Name and Address of Insured:					
Health Problems we should know about:(Allergic to Bee Stings, Asthma, Diabetes, Recent Illnesses or Injuries [anything you have seen a doctor for in the past 6 months], etc.):					
Daily/Regular or "as needed" Medications (ex: Allergy, acne medication, etc.):					
A WBOP chaperone will have the following over-the-counter medications available to treat common conditions: Tylenol or Advil (pain/headaches) Midol (females only - cramps) Benadryl (allergies) Sudafed (congestion) Dramamine (motion sickness) Tums or Pepto-Bismol (upset stomach) Imodium (diarrhea)					
<i>My student may be given these medications if needed:</i> ____ <i>yes</i> ____ <i>no</i>					
All information will be held in the strictest confidence and will be used on an "as needed" basis only.					

Medical History Permission and Release Form

Name: _____ Age: _____

Address: _____ Zip: _____

Incase of an emergency, notify: _____ Phone: _____

Family Physician: _____ Phone: _____

Family Insurance Co. _____ Policy # _____

Insurance Co Address: _____

IMMUNIZATIONS: Tetanus ___ Polio Booster ___ Measles ___ Mumps ___

Other: _____

PAST MEDICAL HISTORY

Asthma___ Sinusitis___ Bronchitis___ Kidney___ Heart___ Diabetes___
Dizziness___ Stomach upset___ Hay fever___ Other_____

Allergies: Food_____ Insect bites/strings_____
Penicillin or other drug (name)_____
Poison Sumac, Oak or Ivy_____
Other_____

Previous operations or serious illnesses_____

Any current medications_____

Special diet (name)_____

Childhood Diseases: Chickenpox___ Measles___ Mumps___ Whooping Cough___

Any medical needs which your child has, of which adult supervisors should be aware:

PERMISSION FOR TREATMENT
My permission is granted for school supervisors to obtain necessary medical attention in case of sickness or injury of my student.

I release and waive, and further agree to indemnify, hold harmless or reimburse the Cobb County School District, the Board of Education, its successors and assigns, its members, agents, employees, and representative thereof, as well as trip supervisors, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation my have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during or in connection with the student's participation in the trip or the rendering of emergency medical procedures or treatment, if any.

DATED this _____ of _____, 20____

Signature of Parent/Guardian NOTARY _____