

WALTON BAND AND ORCHESTRA PARENTS, INC.

MEDICAL INFORMATION, PERMISSION AND RELEASE FORM

Student Name:		Home Phone:	Circle one:	
<small>Last:</small>	<small>First:</small>		Male	Female
DOB:	Grade:	Instrument:		
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)				
My student may be given these medications if needed: ___ yes ___ no				
All information will be held in the strictest confidence and will be used on an "as needed" basis only.				

*** PLEASE FILL OUT BOTH SIDES OF THIS FORM AND ATTACH COPY OF INSURANCE CARD ***

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/stings _____
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

