



Seminole County High School Band

(this must be filled out to participate)

RELEASE FOR STUDENT MEDICAL TREATMENT

I, _____, hereby give permission to participate in the Seminole
parent or guardian

County band program and for medical treatment for

_____ in the event of a medical emergency. I
name of student

understand that I will be contacted as soon as possible if treatment is needed.

Allergies: _____

Medications: _____

Any known medical conditions: _____

INSURANCE INFORMATION

Name of Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Card Holders Name: _____

Contract Number: _____ Group #: _____

Name of Employer: _____ Phone #: _____

Parent/Guardian Address: _____

Home Phone #: _____ Cell phone# _____

EMERGENCY CONTACT (if parent/guardian is not available)

Name: _____

Relationship to student: _____

Address: _____

Phone #: _____ Additional phone# _____

I understand that by signing this form I release Seminole County Schools, faculty, drivers, and chaperones from liability in case of emergency.

Parent Signature _____ Date: _____

