

2019-2020 Coral Glades High School Music Association
ANNUAL PERMISSION FORM FOR MEDICAL TREATMENT
School Board of Broward County, Florida

BAND / GUARD / ORCHESTRA (circle one)

Instrument: _____

Grade for 2019-2020 School Year: _____

Last 6 digits of Student ID: _____

I, the undersigned, being the parent or legal guardian of _____, hereby authorize any necessary treatment for my child while on a trip with Coral Glades High School Music Department throughout the 2019-2020 school year. I also guarantee payment of all charges included during this medical treatment.

Parent: (Please list any/all adults you wish to get communication, legal guardian first)

Name: _____ Cell: _____ Email: _____ Relationship: _____

Name: _____ Cell: _____ Email: _____ Relationship: _____

Name: _____ Cell: _____ Email: _____ Relationship: _____

Student Cell: _____ Email: _____ T-Shirt Size: _____

Address: _____ City/Zip: _____

Adults to notify in case of emergency if above adults cannot be reached:

Name: _____ Telephone(s): _____

Is it OK to send you text message reminders? YES NO If yes, who is your cell provider: _____

Regarding the above-named student, the following information is submitted:

1. Allergies to foods, medications, etc.: _____
2. Special medical problems: _____
3. Current medications? List name and dosage: _____
4. Date of last Tetanus shot: _____
5. Name and phone number of family physician: _____

Insurance Information

(Please check and complete either part A or part B, whichever is applicable.)

_____ **A.** My child is covered by 24-hour student accident and medical insurance.

Insurance Co. Name: _____ Policy: _____ Group #: _____

_____ **B.** I do not have insurance; however, I will pay any and all medical bills for emergency care of my child.

Parent/Guardian Signature

Date