Please complete this form and return ***with a copy of both sides of a family or student health insurance card*** *by February 1, 2024.*

PERMISSION FOR MEDICAL TREATMENT

Cedar Falls High School Band Florida Tour March 9-14, 2024

_____ _____
Student Last Name, First Name, MI. – Print Legibly Date of Birth

Insurance carrier: _____ Policy # _____ Phone: _____

I, the undersigned, being the parent or legal guardian of the above named student, hereby authorize any necessary medical treatment for this person while participating in the Cedar Falls High School Band Florida Tour from March 9, 2024, through March 14, 2024 to Orlando, Florida and all points in transit. I also guarantee payment of all charges incurred during the course of this medical treatment including but not limited to: physician services, hospital, nursing services, x-ray, lab work, drugs, ambulance, etc.

_____
Parent/Guardian Signature Parent/Guardian Name Printed Date

Relationship to student: _____ Witnessed by: _____

Residence address: _____

Emergency Contacts:

Name (Please Print Clearly)	Relationship to student	Phone Number(s)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

In regard to above named student, I submit the following information:

1. **Allergies** to food, medications, etc.: (if none, so state) _____

   _____

2. **Special medical problems**: (if none, so state) _____

   _____

3. List **medications** student will carry on person or in luggage (if none, so state). All medications must be in original packaging.

   Medication _____ Purpose _____

   Medication _____ Purpose _____

   Medication _____ Purpose _____

4. Date of last Tetanus shot: _____

5. Family physician: _____ Phone: _____