WELS Band Festival Medical Consent Form

SCHOOL NAME: ____

Student Name: ____

Address: ____

City/State/Zip: ____

Date of Birth: ___________________ Grade: 9 10 11 12

My family doctor is: ______________________________ Phone: ___________________

Special medical information (i.e. allergies, reaction to medications) that should be known for treatment: ____

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Insurance Company: ____

Policy #: _______________________________________

Policy Holder: __________________________________

In case of emergency, please contact:

Parent: _________________________________ Phone: ________________________

Second Contact: ____________________________ Phone: ________________________

In the event of an emergency, I understand that every effort will be made to contact me. In case I am unable to be reached, I give permission for my child to be treated at a hospital at the discretion of the host director. I agree to pay for any cost incurred in such an instance and further agree not to hold Wisconsin Lutheran High School liable for the cost of health care provided to my child in such an emergency situation.

Parent/Guardian Signature: __________________________________ Date: ___________