2024-2025 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 2024-2025 School Year:_____ **Last 6 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 2024-2025 school year. I also guarantee payment of all charges included during this medical treatment.

Parent: Please list adults to receive communication with the parent or 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: _____

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 must be submitted:

1. Allergies to foods, medications, etc.: _____
2. Preffered Sandwich: Ham Turkey Vegan
3. Special medical issues: _____
4. Current medications? List name and dosage: _____
5. Date of last Tetanus shot: _____
6. 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

Received at Coral Glades High School: By: _____ Date: _____ Entered: _____