CONSENT TO TRAVEL

I, ______________________________, give permission for __________________________________,
(parent or guardian) (name of participant)

to travel with the Brighton High School Band to Orlando, Florida/Disney World & Universal Theme parks. The group will depart on May 5th, 2020 & return on May 10th, 2020.

In case of an emergency, please contact ____
(emergency contact & relationship to participant)

at __________________________ or _____________________________.
(phone number) (second phone number)

CONSENT TO RECEIVE TREATMENT

As parent or guardian of _____________________________________,
(name of student)

I authorize treatment of the above mentioned student by a qualified physician or nurse in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual, trained in first aid, if in the opinion of that individual, delay might endanger his/her life, cause disfigurement or undue comfort. On the Medical Release Form i have listed any allergies, ongoing medical treatment, or medical problems which might influence treatment of the student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the understanding that except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

CONTACT INFORMATION

____

Authorized Signature Date

____

Address

____

Home Phone Email Address

2020 Disney Field Trip Medical Release & Food Allergy Notification Form

(This is NOT your BHS field trip permission form. It will be distributed at a later date for teacher approval & parent signature)

MEDICAL INFORMATION FORM

Student's Name____
(First) (Middle) (Last)

Home Address____
(Street Address)

City____________________ State ____________________ Zip ____________

Home Telephone ____________________ Cell Phone ____________________
(Area code) + (Number) (Area code) + (Number)

Student's date of birth ____________________

Medical problems or allergies which might influence medical treatment (if none, please state "none known")

____

____

Please List any Food Allergies:____

If student is currently under physician's care for medical treatment, please complete the following:

Medication(s) ____

Condition____

Physician's Name____________________ Physician's Telephone #____________________

INSURANCE INFORMATION

Name of Primary Insured ____

Primary Insured's Employer____

Group Number ____________________ Member Number ____________________
**** Please attach a copy of your insurance card to this sheet.