

# MMS Band Student Permission Slip & Medical Authorization Form

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth/Age \_\_\_\_\_

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Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

As parent(s) /guardian(s) of the above student, permission is granted for this student to attend all of the Murphysboro Middle School band trips during the 2010 – 2011 school year. I/We am/are aware that the Murphysboro Middle School requires all participants on a trip to supply the following information in case a medical emergency should arise during this trip.

**1.) Insurance:**

Name of Insurance Carrier: \_\_\_\_\_  
Group/Policy Numbers: \_\_\_\_\_

**2.) Family Physician**

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**3.) Emergency Contact:**

If group chaperones/organizers are unable to contact you or any of the people listed as emergency contacts, they may make whatever arrangements are necessary in an emergency at no expense to the organization. Please list emergency contacts below:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Relationship: \_\_\_\_\_

**4.) Drug Sensitivities/Allergies:** \_\_\_\_\_

**5.) Medical Conditions/Medical Concerns:** \_\_\_\_\_  
\_\_\_\_\_

**6.) Medications/Prescriptions:** \_\_\_\_\_

Prescription \_\_\_\_\_ Time: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Prescription \_\_\_\_\_ Time: \_\_\_\_\_ Dosage: \_\_\_\_\_

NOTE: Parent/Guardian is responsible for assuring all medications, prescriptions or non-prescription

items is supplied and accompanied by the Murphysboro CUSD #186 Medication Authorization form. All medications must be provided in the original container or package and marked with the student's name.

**MEDICAL AUTHORIZATION AND CONSENT:**

In the event of an emergency which would require medical care and treatment to be administered to the student, I/We hereby authorize any physician, hospital, school nurse, group athletic trainer, or other health care provider to give emergency medical care and treatment. The undersigned have read and completed the Student Permission Slip and Medical Authorization Consent Form and declare and affirm that I/We consent to the contents herein stated and that information provided is accurate to the best of my knowledge.

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Parent/Guardian Signature (s):

Date

**State of Illinois**  
**County of Jackson**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2010.

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Notary Public