



Miami Killian Senior High School Cougar Band Medical Release Form

Student _____ Student ID: _____

Parent/Legal Guardian's Name: _____

Date of Birth: _____ Sex: M ___ or F ___

Current Medication Name of Medicine	How much do I take?	When do I take it?	What do I use it for?

Medical Conditions:

- | | | |
|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Other: _____ | | |

Blood Type: _____ Allergies: _____

Date of last Tetanus Shot: _____ Prior Surgery? _____

In case of an emergency please contact:

Name: _____

Relationship to student: _____

Phone #: () _____ () _____
() _____ () _____

OR:

Name: _____

Relationship to student: _____

Phone #: () _____ () _____
() _____ () _____

Physician's Name: _____

Address: _____

Phone #: () _____ () _____

Miami Killian Senior High School Cougar Band

Medical Release Form

Page 2

Insurance Company: _____

Phone #: _____

Policy Holder's Name: _____

Relationship to Student: _____

ID#: _____ Group/Policy #: _____

I understand and accept that the risk of injury is possible while participating in marching band activities. I agree to indemnify and hold harmless anyone associated with Dade County Public Schools (DCPS), and the Cougar Band Patrons, Inc. (CBPI), for all medical expenses incurred as a result of participation in marching band activities. I hereby acknowledge that DCPS and CBPI cannot be held responsible for any injury to my son/daughter.

Statement of Consent: (To be signed in the presence of a legalized notary public.)

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical attention to be administered to my child, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendations of qualified medical personnel.

_____ Signature of Parent/Legal Guardian

THE STATE OF: _____)

COUNTY OF _____)

BEFORE ME, the undersigned authority, on this day personally appeared _____ known to me or provided identification _____, to be the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn an oath, acknowledged that he/she had executed the same for the purposes and consideration therein expressed and that the foregoing statements are true and corrected.

GIVEN under my hand and seal of office, this _____ day of _____ 20 ____.

(Signature of Notary)

(Name of Notary)

(Commission Expiration Date)