Wunderlich Band
Medical Release/Authorization Form & Information Sheet
2022-2023

Please Print

Student: _____ Grade:_____
LAST FIRST MIDDLE INITIAL

Instrument:_____

Band Class:_____(Beginner, Concert B, Concert A, Symphonic)

Address: _____

City/Zip: _____Home Phone: _____

Father/Guardian: _____ Work/Cell Phone: _____

Mother/Guardian: _____ Work/Cell Phone: _____

Alternate Adult Name: _____ Phone: _____

Emails **Student Email:_____**

Father/Guardian Email: _____

Mother/Guardian Email: _____

The above named student has my permission to participate in school sanctioned activities as a member of the Wunderlich Band during the 2021-2022 school year. Students even when off campus, are still subject to the school rules and regulations when participating with the Wunderlich Band. I understand that any student who does not conduct himself/herself properly may be (1) sent home at the parent's expense; (2) prohibited from participating in future activities of this organization; and/or, (3) subject to other appropriate disciplinary action.

By signing this document, the parent and/or legal guardian releases the Klein Independent School District and the Wunderlich Band directors, chaperones, volunteers, etc. from any and all claims resulting from the injury of the above named student or the loss of property of the above named student while participating in any activities connected with the Wunderlich Band. This is to further authorize any hospital, physician, emergency medical technician or other health care provider to provide such medical treatment and care as may be required for the health, safety and well being of my child. I hereby release any claims that I might otherwise have against any such health care provider for the rendition of medical services to my child in reliance upon this Medical Authorization.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Insurance Coverage

Insurance Company: _____

Policy Number: _____ Group in Name of: _____

Name of Policy Holder: _____

Name of Doctor: _____ Phone: _____

Current Medications: _____

Known Drug Allergies: _____

Known Medical Conditions: _____