MEDICAL CONSENT RELEASE FORM

Name of Participant:	Date of Birth:	Age:	Sex:
Home Address:		Telephone:	
In the event of an emergency, please notify:		Telephone:	
Name:	Relationship:	Telephone:	
Name:	Relationship:	Telephone:	
Name of Personal Physician:		Telephone:	
Personal Health/Accident Insurance Carrier:		Policy ID#:	

The undersigned desires that said student receive the proper medical treatment in the event of illness or accident, consents to the administration of all medical treatments as may be deemed necessary, and accepts financial responsibility for said treatments. In accepting this consent, Giles High School Bands agrees to promptly notify the member's parent/guardian or other identified emergency contact in the event of any serious accident or illness.

_____ _____/ _____/ _____

Signature (Parent/Guardian) Date