



# GREER BANDS



## MEDICAL RELEASE FORM

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

### EMERGENCY CONTACT PERSON AND NUMBERS

PLEASE PUT ALL CONTACT NUMBERS  
BE SURE THAT THESE CONTACTS CAN SPEAK FOR YOUR OWN CHILD IN CASE OF EMERGENCY

NAME	RELATIONSHIP	PHONE
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS OF DOCTOR \_\_\_\_\_

### INSURANCE INFORMATION

COMPANY NAME \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

NAME OF ADULT CARRIER \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WITH THIS FORM

### HEALTH HISTORY

ALLERGIES  
PLEASE LIST ANY MEDICATION, FOOD OR OTHER ALLERGIES

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**GENERAL INFORMATION**

GLASSES, CONTACT LENS OR MEDICAL DEVICES NEEDED

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**MEDICATIONS**

LIST ANY MEDICATION TO BE TAKEN (OVER THE COUNTER OR PRESCRIPTION) ALONG WITH THE DOSAGE. BOTTLES ARE TO BE LABELED WITH THE CORRECT NAME, DOSAGE AND SCHEDULED TIME

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**ILLNESS AND SURGERIES**

LIST ANY SURGERIES OR ANY PREVIOUS ILLNESSES

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**IMMUNIZATIONS**

ARE YOUR IMMUNIZATIONS UP TO DATE? \_\_\_\_\_

DATE OF LAST TETANUS SHOT \_\_\_\_\_

I hereby give my permission for the Greer Band Staff and/or volunteer medical first aid/chaperones to dispense the above listed medication, over the counter and or prescribed, which I have appropriately provided. In case of an emergency and I cannot be reached by phone, I authorize the Greer Band Staff and/or medical volunteer or chaperone to obtain medical treatment for \_\_\_\_\_ . Hospital medical staff is authorized to make examination and to render any medical and/or surgical treatment deemed necessary for \_\_\_\_\_'s health and welfare. I also authorize release of treatment information to the proper insurance company for payment purposes.

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Parent/Guardian's signature                      Date

Please list and label all appropriate phone numbers:

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