

PRINT Student's Name \_\_\_\_\_ ID# \_\_\_\_\_

Arcadia Music Club  
Gator Bowl, Florida  
STATEMENT AND RELEASE FORM

I (We), the undersigned, parent(s)/guardian(s) of the above named camper, do hereby give our permission for him/her to attend and participate in the Arcadia High School Band Gator Bowl trip, scheduled December 29, 2008 through January 4, 2009. I(We) release the Arcadia Unified School District, the Arcadia High School, the Arcadia Music Club, Inc., their representatives and contractors of all liability in case of illness or accident to the above mentioned student and will take full responsibility for his/her welfare should illness or accident occur.

I (We) am also, aware that participants are to abide by all rules and regulations governing conduct during the trip. In the event my child violates Arcadia High School or Arcadia Music Club's rules, regulations, or procedures, he/she may be subject to dismissal prior to the trip's completion, at the parents' expense. In this event, I (we) agree to provide transportation home for my child immediately upon receiving notification. I (We) also agree to pay for any property damage caused by my child.

Parent(s) or Guardian(s) signature on this form gives Arcadia Music Club's trip personnel authorization to call any reference listed in case of emergency; and also authorizes their son/daughter to be transported by bus and plane in order to participate in the Florida Trip.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Father/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Mother/Guardian

I have read the above and I acknowledge and agree that I will be bound by and comply with Arcadia High School and Arcadia Music Club's rules, regulations, procedures, and responsibilities during this year's Florida trip.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student

Arcadia Music Club  
**Consent to Treat Form**  
(minor)

I (We), the undersigned, parent(s)/guardian(s) of \_\_\_\_\_ a minor, do hereby consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be rendered to said minor, under the general or specific instructions of a licensed medical doctor or dentist, whether such diagnosis or treatment is rendered at the doctor's office or at a licensed hospital.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given in order that said physician may have the opportunity to exercise his/her best judgment as to the action which may be necessary or required to protect the life and health of said minor child. I (We) have also read and have fully completed the attached Medical History Form.

It is also understood that any such accident or illness which requires any specific diagnosis and/or treatment will be reported to the parent(s) or legal guardian(s) as soon as possible.

Date	Signature of Father/Guardian	Phone #			
Date	Signature of Mother/Guardian	Phone #			
Date	Signature Witness (over 18)	Phone #			
<table border="0" style="width: 100%;"><tr><td style="width: 50%;">Address of Witness</td><td style="width: 25%;">City</td><td style="width: 25%;">Zip</td></tr></table>			Address of Witness	City	Zip
Address of Witness	City	Zip			

**Medical Insurance (If nothing applies, please write "NONE")**

Company Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Certificate # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

\*\*\* Note: The above **witness signature is mandatory**. (A witness is any adult, non-family member who is verifying that the signature is the named person.)

**MEDICAL RELEASE FORM**  
**Parental Consent for Medical Treatment**

I, the undersigned, being the parent, legal next-of-kin, or legal guardian of \_\_\_\_\_  
ID# \_\_\_\_\_ hereby authorize any necessary medical treatment for this person during  
the time in which he/she is participating in the Gator Bowl Music Festival and extended trip from  
December 29, 2008 to January 4, 2009. I also guarantee payment of all charges incurred during the  
course of said medical treatment (physician, hospital, X-ray, lab, medication, ambulance, etc.) In regard  
to the above mentioned person, I submit the following information:

1. Allergies to food, medications, etc. (If none, state it so.): \_\_\_\_\_

\_\_\_\_\_

2. Special medical problems (If none, state it so.): \_\_\_\_\_

\_\_\_\_\_

3. Does participant carry or require medications? (If none, state it so.)

Medication: \_\_\_\_\_ Purpose: \_\_\_\_\_

Medication: \_\_\_\_\_ Purpose: \_\_\_\_\_

4. Date of last Tetanus shot: \_\_\_\_\_

5. Family Physician: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed by: \_\_\_\_\_

Printed Name Parent/Guardian: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Phone Daytime: \_\_\_\_\_

EMAIL Address: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

**Medical Insurance Information:**

Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Certificate # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

**Please be sure to update trip personnel if any problems develop between now and the time  
of the trip so that we have current information on your student's health.**