Medical Clearance Form

TO WHOM IT MAY CONCERN: I, the undersigned, being the parent, legal next-of-kin, or legal guardian of __________________________ hereby authorize any necessary medical treatment for this person while participating in Lancer Marching Band activities. I also guarantee payment of all charges incurred during this medical treatment (physician, hospital, x-ray, lab drugs, ambulance, etc.) and submit the following information.

1. Allergies to foods, medications, etc. (If none, so state)

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2. Special medical problems (If none, so state)

___

3. Does the participant carry medications on person? (If none, so state)

___

4. Date of last Tetanus shot ___________________________

5. Family Physician ________________________________

   Office Address __________________________________

   City _____________ State ___ Zip _____ Phone ________

Other important information:

PARENT OR LEGAL REPRESENTATIVE SIGNATURE _______________________

Print Name of Above Signature _______________________

PARENT(S) ADDRESS: ____

Street City State Zip

DAY PHONE ___________________ (Father) ________________ (Mother)

NIGHT PHONE ___________________ (Father) ________________ (Mother)

BAND NAME: Mankato 77 Lancers

CONTACT: Michael Hench 507-215-0842 Cell

SCHOOL: Lincoln Community Center

ADDRESS: 110 Fulton St

CITY, STATE, ZIP: Mankato, MN 56001