

# SCHURR HIGH SCHOOL PERFORMING ARTS DEPARTMENT

Montebello Unified School District  
820 North Wilcox Avenue, Montebello, CA 90640  
(626) 457-2618, (323) 887-7900 OR (323) 887-3090 Extension 1-6639

## AUTHORIZATION TO TREAT A MINOR

(This form can also be downloaded at [www.schurrmusic.org](http://www.schurrmusic.org))

PARTICIPATION 20\_\_ - 20\_\_ (check applicable program(s))

Marching Band/Concert Band      Jazz Band      Orchestra      Drill Team      Color Guard

Check grade entering Fall 20\_\_

(check one)      Freshman      Sophomore      Junior      Senior

### MEDICAL RELEASE FORM FOR: (Student Name)

STUDENT ID: \_\_\_\_\_ SECTION: \_\_\_\_\_

Last Name

First Name

Middle Initial

I (we) the undersigned parents or legal guardian of the above named student, a minor, have entrusted such minor into the care of Mr. Antonio Castro, Schurr High School Instrumental Music teachers, and/or other designated adults for the purpose of taking part in all of the field trips, bus transportation and transfers, performances, and all other activities and obligations as related to being a student participant in the Schurr High School Performing Arts Department.

In such connection, I (we), the undersigned, authorize such caring adults to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to such minor under the general or special supervisions, and on the advice of, a physician and surgeon licensed under the provisions of the Medicine Practice Act, or, if in another state or country, under the provisions of law in that state or country governing the practice of medicine; and further authorize such caring adults to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to such minor by a dentist licensed under the provisions of the Dental Practice Act, or, if in another state or country, under the provisions of law in that state or country governing the practice of dentistry. The decision by such caring adults shall be made after due consideration of all the facts and circumstances that reasonable parents in a similar situation would take into consideration. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the above named minor, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

I (we), the undersigned, additionally authorize such caring adults to arrange for treatment by emergency medical technicians (i.e., paramedics), and hire an ambulance or other emergency vehicle to transport such minor to a suitable place where medical or dental care is provided. It is understood that Montebello Unified School District cannot assume responsibility for the payment of medical fees or expenses incurred. I (we), the undersigned, understand that these arrangements are to be made at my (our) expense

List or attach any restrictions to the foregoing.....if none, please complete the back of this "AUTHORIZATION TO TREAT A MINOR" and sign in ink below.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

Signature(s) of Parent(s)/Guardian(s):

**MUST BE SIGNED IN  
BLUE INK**

**COMPLETE ALL INFORMATION ON THE REVERSE OF THIS FORM.**

**Complete Two (2) Original Forms for each Program selected**

<b>Student's Name (Last, First, Middle) :</b>	<b>Student's Date of Birth mm/dd/yyyy):</b> / /
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<b>Name(s) of Parent(s)/Guardian(s):</b>	<b>Parent's e-mail address</b>
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<b>Home Phone Number(s) including area code(s):</b> ( )	<b>Student's e-mail address</b>
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<b>Work Phone Number(s) including area code(s):</b> ( )	<b>Other Phone Number(s) including area code(s):</b> ( )
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<b>Residence - Please list street information, city, and zip code:</b> _____
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<b>Other Designated Emergency Contact Person (People):</b>	
NAME : _____	TELEPHONE # :_( )_____
NAME : _____	TELEPHONE # :_( )_____

<b>FAMILY PHYSICIAN – Please list the physician's name, address and phone numbers(s):</b>
NAME: _____-( )_____
ADDRESS:

<b>MEDICAL INSURANCE COMPANY and POLICY NUMBER – If none, please write "NONE":</b> _____
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<b>Wears contact lenses?</b> YES                  NO
<b>May this minor be given acetaminophen (i.e. TYLENOL™ Brand)?</b> YES                  NO
<b>Date of last TETANUS BOOSTER:</b>

<b>Please list any known allergies to foods or drugs that will prevent student from participating in band related activities: If none, please write "NONE":</b> _____
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<b>Please list any medications currently prescribed or taken by this minor that is required to participate in band activities: If none, please write "NONE":</b> _____
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<b>Please list any restrictions from physical activities – Please attach a signed physician's note that details the nature of any conditions that would limit or restrict full participation. If none, please write "NONE":</b> _____
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<b>Please identify any other conditions, medical history or information that may concern this minor should an emergency occur. If none, please write "NONE":</b> _____
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