



### Minor Participation and Medical Release Form

**Please Print**

Student's Name: \_\_\_\_\_ Home Phone: ( \_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

I hereby give permission for my son/daughter to participate with the Tampa Bay Pride Band and Tampa Bay Symphonic Winds, a 501(c)(3) nonprofit organization. I hereby hold the Tampa Bay Pride Band and Tampa Bay Symphonic Winds harmless for any/all injuries or damages for the above child's participation in any event and I do, for myself, my heirs, executors and administrators, remise, release, waive and forever discharge the Tampa Bay Pride Band and Tampa Bay Symphonic Winds and all of its officers, agents and employees, acting officially or otherwise, from all claims demands, actions, or causes of action, on account of any injury, death or property damage which may occur at any time or for any cause during their participation in any event.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Student

### Emergency Medical Treatment Permit

Family Physician: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_

**Please list any medications and dosages as well as allergies, allergic reactions and any other information necessary on the back of this form.**

I hereby give permission for \_\_\_\_\_ to participate with the Tampa Bay Pride Band and Tampa Bay Symphonic Winds, and I assume responsibility for the behavior and actions of my son/daughter. Also, in case of emergency, I hereby give my consent for a qualified physician to perform any medical or surgical procedures she/he deems necessary to the welfare of this student while participating with the Tampa Bay Pride Band and Tampa Bay Symphonic Winds. It is understood that the with the Tampa Bay Pride Band and Tampa Bay Symphonic Winds coordinator and medical personnel will make every attempt to contact parents, guardians, relatives listed prior to taking any such actions. Further, this authorization permits said physician to hospitalize, secure appropriate consultation, order injections, anesthesia (local, general or both) or surgery for this applicant if emergency conditions warrant. The undersigned does hereby assume and agree to pay any indebtedness for physician's or surgeon's fees and hospital charges for such service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relation to Student: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_\_