

Participant Name \_\_\_\_\_

**Medical Release Form**  
**2023-2024 NYC Music Trip**

**TO WHOM IT MAY CONCERN**

In our absence, the bearer of this letter has permission to obtain any medical or emergency treatment that he or she deems necessary.

\_\_\_\_\_  
*Participant Name (First, Middle, Last)                      Date of Birth                      Age as of June 14, 2024*

\_\_\_\_\_  
*Parent/Guardian Name(s)                                      Relationship to Participant*

\_\_\_\_\_  
*Parent/Guardian Phone (cell)              Parent/Guardian Phone (home)              Parent/Guardian Phone (work)*

\_\_\_\_\_  
*Participant's primary physician                      Physician's telephone number*

For the safety of the participant, please indicate any allergies or physical limitations we should be aware of:

\_\_\_\_\_  
\_\_\_\_\_

List any medications the participant is presently taking, with or without prescription (including aspirin or Tylenol). Students are responsible for bringing and taking their own medication.

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Parent/Guardian signature                                      Date*

State of Wisconsin, County of Dane.

The foregoing instrument was acknowledged before me on \_\_\_\_\_ (date) by \_\_\_\_\_ (name of person acknowledging).

(Notary Seal)

\_\_\_\_\_  
Signature of Notary Public

My commission expires: \_\_\_\_\_

Participant Name \_\_\_\_\_

## **Participant Insurance Information**

### **2023-2024 NYC Music Trip**

In order to cover any unlikely but possible scenarios of severe illness or accident which would necessitate hospital emergency room service, please fill in the following information as thoroughly as possible. This information will be considered confidential and will be kept by the director and your child's chaperone, and used if the need should arise.

### **Primary Coverage Information**

Subscriber Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Carrier Name (Employer) \_\_\_\_\_

Insurance Company Address and Phone \_\_\_\_\_

### **Secondary Coverage Information**

Subscriber Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Carrier Name (Employer) \_\_\_\_\_

Insurance Company Address and Phone \_\_\_\_\_