



## Parent Waiver and Release of Claims and Consent for Medical Treatment for Student Travel

I, the undersigned parent or guardian, hereby give permission for my child, \_\_\_\_\_, to travel on transportation provided by Leander Independent School District to Vandegrift High School Band functions during the 2010-2011 school year.

In regards to the above trip/activity, I release and discharge the Leander ISD, its employees, officers, agents and assigns from all claims which I may have or which my heirs, administrators, or assigns may have or claim to have against Leander ISD, its employees, officers, agents and assigns for all personal or property injuries caused by or arising out of the above-described trip/activity.

For the same consideration, I recognize that student participation in this trip/activity is voluntary, and I hereby expressly assume all risk of personal injury to participant and loss or damage to property of participant or any other loss of every nature.

I acknowledge that my child understands that the activity involves possible inherent risks of physical harm because of the nature of the activity itself and/or the physical environment of the location(s) wherein the activity is conducted and that it is participant's responsibility to use special care and caution, including but not limited to, appropriate protective apparel and/or equipment, to avoid risk of injury.

Finally, I authorize the sponsor(s) to consent to medical treatment of my child, \_\_\_\_\_, in the event of medical emergency on the above-described trip/activity.

I have read this Waiver and Release of Claims and Consent for Medical Treatment and understand all of its terms and conditions. I execute this Waiver and Release of Claims and Consent for Medical Treatment voluntarily and with full knowledge of its significance.

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

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Signature of Parent or Guardian

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Address and Phone Number of Parent or Guardian

*Please complete the Medical Information on the next page.*





## Student Medical Information

Student Name: \_\_\_\_\_

Student Birthday: \_\_\_\_\_ Student Social Security #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Alternate Emergency Contact Name: \_\_\_\_\_

Alternate Emergency Contact Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Important Medical Information (*drug or food allergies, special medical conditions, medications, etc.*):

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

### Insurance Information

Insurance Plan Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

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

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Member Number: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Plan Number: \_\_\_\_\_ Additional Information: \_\_\_\_\_

**REQUIRED: Please attach a copy of your insurance card (front and back).**

