OLA INDOOR PERCUSSION

2026-2027 MEDICAL FORM

STUDENT NAME _____ GRADE _____
(2026-2027 School Year)

SCHOOL _____

HOME ADDRESS _____

CITY _____ , GEORGIA ZIP _____

MOBILE _____ DATE OF BIRTH _____

PARENT | GUARDIAN NAME _____

RELATIONSHIP _____ MOBILE _____

Dietary Needs _____

Skin Allergies _____

Food Allergies _____

Allergies to any medications _____

Any recent past surgeries _____

Ongoing past medical conditions _____

Other medical concerns or limitations_____

Does your child take any medications regularly: Yes ☐ No ☐

If yes, please list type and dosage _____
_____

Please select the following “over the counter” medications that the Ola Bands staff/parent volunteers may administer to your child if needed: *(check all that apply)*

☐ Ibuprofen/Advil ☐ Tylenol ☐ Benadryl ☐ Dramamine ☐ Neosporin ☐ Cough Drops

☐ I do not give consent for any medications to be given to my child.

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My child is medically insured: Yes ☐ No ☐ Policy Holder _____

Name of Insurance Company _____

Policy Number _____ Group Number_____

Permission is granted to the band directors and designated chaperones to administer first aid, to obtain the services of a licensed physician, and to arrange transportation to a medical facility in case the person named is seriously ill or injured and requires emergency medical attention.

Yes ☐ No ☐ Signature _____

Permission is granted to the attending physician to render any treatment necessary for the patient's welfare. The responsibility for all expenses incurred will be assumed by the person whose signature appears below.

Yes ☐ No ☐ Signature _____

I hereby release and discharge the Ola Bands band directors and volunteers from all liability in case of accident or any other injury which might occur to my child through administering first aid and transportation to a medical facility.

I hereby release said aforementioned officiants from any liability, injury, or damage that may occur.

Yes ☐ No ☐ Signature _____