LASSITER HIGH SCHOOL BAND
2601 SHALLOWFORD ROAD, MARIETTA, GA 30066

INSURANCE INFORMATION

Please include a copy of insurance card front and back.

Carrier _____ Policy # _____

GP Plan # _____ Physician _____

Phone # _____

If no insurance, please complete the following:

FOR AND IN CONSIDERATION OF EMERGENCY SERVICES AND GOODS RENDERED BY OR THROUGH THE ATTENDING PHYSICIAN(S) THE UNDERSIGNED GUARANTEES PAYMENT IN FULL, IMMEDIATELY UPON RECEIPT OF FINAL BILLING.

Signature of
Parent or Guardian: _____

Print Name _____

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, being the parent, legal guardian, or next of kin of

Student _____ Date of Birth _____

hereby grant authorization to Band Directors, chaperones of Lassiter Band Booster Association, standing in loco parentis, to obtain emergency medical and/or surgical treatment and procedures from a physician or hospital emergency room on behalf of the above named minor. I also give permission to administer over the counter medication if necessary.

Signature _____ Relationship_____

Print Name _____