



PASADENA TOURNAMENT *of* ROSES

## Student Participant Medical Release Form Pasadena Tournament of Roses

This form is to be completed for all participants in the Pasadena Tournament of Roses Parade group of events. Completion of this form provides for express consent to emergency medical treatment in the absence of parent or guardian. This form is **required** and must be carried by the participant at all times. Failure to do so may result in the delay of necessary emergency medical care and/or release from medical facility.

Student Name (First): \_\_\_\_\_ (Last): \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M / F Blood Type: \_\_\_\_\_ Last Tetanus inoculation within 5 years?: Y / N within 10 years?: Y / N

Known Allergies: \_\_\_\_\_

Current Medical Conditions: \_\_\_\_\_

Medications Being Taken: \_\_\_\_\_

Special Needs: \_\_\_\_\_

Student's School or Band Name: \_\_\_\_\_

Band Director or Leader: \_\_\_\_\_ Telephone: \_\_\_\_\_

Local Residence / Hotel: \_\_\_\_\_ Local Telephone: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Carrier Billing Address/Phone: \_\_\_\_\_

### Parental Authorization / Permission to Treat & Release

*"I hereby authorize any and all medical treatment in my absence for my son or daughter, in conjunction with duties related to the Pasadena Tournament of Roses Parade events, as may be deemed necessary by first aid and emergency medical personnel of, but not limited to, the American Red Cross, the Pasadena Fire Department and/or select area hospitals." Release from the hospital by recognized Band Director(s) listed above or a credentialed Tournament of Roses Music Committeeman is authorized.*

Parent / Guardian Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Travel to Rose Parade? Y / N

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Pager / Cell phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Drivers Lic. Number: \_\_\_\_\_ State: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Telephone: \_\_\_\_\_

School Supervisor Witness: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

ARC File: ToR Medical Release Form.doc SGV/HES090501v2