

## JAZZ BAND HANDBOOK AGREEMENT FORM

This agreement form is to be signed by the student and a parent and returned to Mr. Hartman by Friday, September 4<sup>th</sup>. Please also fill out the emergency medical form on the back of this paper for situations where the jazz band may/will be traveling this school year.

I have read, understand, and agree to comply with the jazz handbook. I also understand that my student, \_\_\_\_\_, needs to obtain the required

(Student name)

concert dress clothing and bring in a jazz CD for our student listening rotation (bring CD to class on September 4<sup>th</sup>). FRESHMEN must also purchase a tuner/metronome. Checks can be made payable to "Moeller Music Centers" for \$33.00 and are due on Friday, September 4<sup>th</sup>. Freshmen who already own a tuner/metronome do not need to purchase another.

\_\_\_\_\_  
(Student signature)

\_\_\_\_\_  
(Parent signature)

Parent email address(es): \_\_\_\_\_

### **\*\*Please turn over to fill out emergency medical form\*\***

As you know, the amazing opportunities which Lakota jazz students enjoy would not be possible without outstanding parental support. Please read the list of volunteer possibilities below and let us know how you would like to contribute to the success of our jazz students. Please feel free to check one or more items. Thank you for your continued support of Lakota jazz students!

\_\_\_ I am interested in helping with administrative activities during the day.

\_\_\_ I am interested in helping with the Jazz Swing Dance

\_\_\_ I am interested in helping with the Cool Jazz 'N Hotcakes Pancake Breakfast.

\_\_\_ I am interested in chaperoning if/when the band should travel.

\_\_\_ I am interested in helping the jazz band financially (equipment, guest artists, etc.)

\_\_\_ Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
(Please print your name)

\_\_\_\_\_  
(Primary contact number)

Check here if you do not want to receive general information via e-mail

### LAKOTA SCHOOL DISTRICT EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent or guardians cannot be reached.

Please use Blue or Black ink.

Student Address \_\_\_\_\_ Student Name \_\_\_\_\_ Sex \_\_\_\_\_  
Zip \_\_\_\_\_ School \_\_\_\_\_ M / F

Home Phone # \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Room # \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address (if different than student) \_\_\_\_\_ Home Phone \_\_\_\_\_  
E-mail address \_\_\_\_\_ Cell/Pgr \_\_\_\_\_  
Step Mothers Name \_\_\_\_\_ Work Number \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address (if different than student) \_\_\_\_\_ Home Phone \_\_\_\_\_  
E-mail address \_\_\_\_\_ Cell / Pgr \_\_\_\_\_  
Step Father's Name \_\_\_\_\_ Work Number \_\_\_\_\_

Guardian's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
(if other than parents)  
E-mail address \_\_\_\_\_ Cell/Pgr \_\_\_\_\_

Person(s) who may be notified and to whom your child may be released if school cannot reach you.

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_
2. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_
3. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

The School Nurse may share health information with appropriate school personnel to aid in present and future educational decisions.

Doctor to be called \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist to be called \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred local hospital \_\_\_\_\_

#### PART 1-TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctor or in the event the designated preferred practitioner is not available by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Date \_\_\_\_\_ Signature of Parent / Guardian \_\_\_\_\_

#### PART 2- TO REFUSE CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take NO action or to: \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent /Guardian \_\_\_\_\_

Lakota Local School District Form 6510B

Cross-Reference: Board Policy 6510

Adopted 08/23/2004