



ARCADIA UNIFIED SCHOOL DISTRICT

# ARCADIA HIGH SCHOOL

## EMERGENCY CONTACT FORM



### *For Music Students*

Student Last Name	Student First Name	Student E-mail	Class of	ID #:
Parent (1) Last Name	Parent (1) First Name	Parent (1)E-mail	Parent (1) Phone #	
Parent (2) Last Name	Parent (2) First Name	Parent (2)E-mail	Parent (2) Phone #	
Street Address		City	State	Zip
Emergency Contact Last Name	Emergency Contact First Name	Emergency Contact Phone # (1)	Emergency Phone # (2)	
Physician Last Name	Physician First Name	Physician Phone #		
Insurance Company	Insurance Certificate/Group #'s		Insurance Phone #	

Known Allergies/Medical Conditions:	<b>IMPORTANT: Please Note!</b> <i>No insurance is provided for these activities by Arcadia Unified School District, Arcadia High School, or AHS Associated Student Body.</i>
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<b><u>ACTIVITY – PLEASE CHECK ALL THAT APPLY</u></b>			
<input type="checkbox"/> Orchestra 1	<input type="checkbox"/> Orchestra 2	<input type="checkbox"/> Orchestra 3	<input type="checkbox"/> Color Guard
<input type="checkbox"/> Concert Band 1	<input type="checkbox"/> Concert Band 2	<input type="checkbox"/> Concert Band 3	<input type="checkbox"/> Percussion
<input type="checkbox"/> Choir	<input type="checkbox"/> Chanteurs	<input type="checkbox"/> J cto qpkz	

- Parent signature on this form is the school official's authorization to call any reference listed in case of emergency; and also authorizes your son/daughter to be transported to an event and return to school in order to participate in a school program or activity by either school or commercial bus. Special circumstances may require transportation by private automobile driven by teachers or parents.
- We, the undersigned, parent(s)/guardian(s) of the above named student, a minor, do hereby consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of the above named physician, M.D., at the number listed above or the Emergency Room Physician, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage said physician(s) to exercise his/her best judgment as to requirements of such diagnosis or treatment.
- This consent shall remain effective until revoked in writing, or until the end of the current school year (**June, 2016**), or until child's 18<sup>th</sup> birthday.
- This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California.

	_____	Date		_____	Date
Student Signature			Parent (1 or 2) Signature		
			<i>Required for ALL Students regardless of age</i>		