## SINGING IN WISCONSIN FESTIVAL November 10, 2018

## PERMISSION FORM

To: Katelyn Peterson State Chairperson

10. 12mm person			
My son/daughter "Singing in Wisconsin" festival on Saturday, Nov	has permission to attend the WCDA y, November 10, 2018.		
I understand that the students will be properly chaperoned at all times.			
understand that if my son/daughter requires medical treatment, a WCDA committee member will try to contact the parent/guardian.			
I will not hold any WCDA member or WCDA/Ao in case of accident or treatment.	CDA liable or responsible for any malpractice		
My permission is also given for my child to receive emergency medical treatment in case of injury or illness. This treatment includes non-life threatening (band-aids) to lifesaving emergency care (broken bones, allergic reactions, etc.)			
I further understand that if my son/daughter is involved in any discipline problems, he or she will be treated as if attending regular school activities on campus. Any infraction will result in the student being sent home at the student's/parent's expense.			
I understand that photographs will be taken at this WCDA event for publication in WCDA "Singing in Wisconsin" festival brochures and/or any other WCDA publications.			
I have read the above information and fully under	estand and agree with the content of this form.		
Signature of Parent/Guardian	Date:		
Signature of Participant	Date:		

BOTH SIDES OF THIS FORM MUST BE COMPLETED AND TURNED IN AT THE "SINGING IN WISCONSIN" FESTIVAL REGISTRATION TABLE ON NOVEMBER 10, 2018, IN ORDER TO PARTICIPATE IN THE FESTIVAL.

## WCDA "SINGING IN WISCONSIN" EMERGENCY TREATMENT INFORMATION AND CONSENT SATURDAY, NOVEMBER 10, 2018

Name:	Date of Birth:	_ Age: Grade:
Contact Parent:	Cell Phone: (	)
Address:	Home Phone: (	)
	Work Phone: (	)
Person to Contact (if parent/guard	dian cannot be reached):	
Home Phone: ( )	Cell Phone: (	)
Insurance Company:	Policy Number: _	
Family Doctor:	Phone Number: (      ) _	
Allergies:		
Medications:		
List Restrictions (if any) to medica etc:	tions that ay be dispensed for h	eadaches, colds, sore throats,
List any physical restrictions:		
Contact Lenses? (Circle one) YES	S NO Date of last teta	nus shot:
PERMISSION TO TREAT		
We/I, the parent/guardian of		
Give permission for emergency me	print full nar) edical treatment of this child in	•
Signature of Parent/Guardian:		date:
Signature of Participant:		
		(Please fill out both sides.)