MOUNT DORA HIGH SCHOOL BAND

COMMITMENT FORM 2023 - 2024 SCHOOL YEAR

FAIR SHARE BAND FEE: $300.00

1st installment of $100 by registration June 1st, 2023 or second registration July 1st, 2023
2nd installment of $100 by September 1st, 2023
3rd installment of $100 by November 1st, 2023

AUXILIARY SHARE BAND FEE: $400.00

4th installment of $100 by January 1st, 2024

Personal apparel estimated costs: Personal items students keep from year to year. Bibbers, Dinkles, Shorts, cap each students keeps.
Under Uniform of show shirt, cap, and shorts $50
Dinkles (black marching shoes) $30
Bibbers(marching pants) - $50

Auxiliary will be responsible for gloves - $20, Tights - $20, and leotards - $50.

There will be several fundraising opportunities provided to students to earn credit towards their Fair Share Fee balance and personal apparel cost.

We will also fundraise as a group for the general Band Fund since the Fair Share Fee does not cover the total annual budget for the Band and we wish to keep the individual Fee as low as possible. The Fair Share Fee at Mount Dora is currently one of the lowest in Lake County.

Please sign and return this form along with the other registration documents and the initial investment of $100 on initial registration. Please make all checks payable to: MDHS Band Boosters, Inc. You can also pay using Venmo (found on the website). ALL students need to complete this packet.

Band Camp: **Week 1** ***- July 24th - July 28th….8:00am - 5:00pm***

Week 2 - July 31st - August 4th….3:00pm - 9:00pm

Band Fair Share fees are non-refundable

Commitment

My signature below indicates that my child and I are making the commitment to become a member of the Mount Dora High School Band Program for the 2023 - 2024 school year. I understand that there is a financial obligation as outlined above.

Student Name (printed) _____Student Signature_____

Parent Name (printed) _____ Parent Signature_____

LAKE COUNTY SCHOOLS

FIELD TRIP/SCHOOL ACTIVITY
PARENT CONSENT/LIABILITY WAIVER/MEDICAL RELEASE

☐ OVERNIGHT
☐ OUT-OF-STATE
☐ OFF CAMPUS

Student _____ School _____
Club/Group/Class _____ Supervising Faculty Member _____
Activity _____ Location _____
Date & Time of Departure _____ Date & Time of Return _____
Method of Transportation : ☐ School Bus ☐ Charter Bus ☐ Private Car ☐ Leased Vehicle ☐ Walking ☐ Other

MEDICAL INFORMATION

Does your child have any of the following conditions?
Epilepsy/Seizures ☐ Yes ☐ No Motion Sickness ☐ Yes ☐ No Diabetes ☐ Yes ☐ No
Any Medication ☐ Yes ☐ No Asthma/Wheezing ☐ Yes ☐ No Heart Disease ☐ Yes ☐ No
Muscular/Skeletal Problems ☐ Yes ☐ No Hemophilia/Bleeding Disorders ☐ Yes ☐ No Allergies: _____

Is there any other condition which might possibly require treatment and/or medication during the trip? Yes ☐ No ☐ If yes, you must complete and attach the Administration of Non-Prescription Medication Consent Form and/or the Administration of Prescription Medication Consent Form.

PARENT CONSENT / LIABILITY WAIVER / MEDICAL RELEASE

I/We hereby give permission for my child to accompany employees of the LCSB, acting as chaperones, to _____ for the days indicated above. I/We will not hold the LCSB nor their agents or employees accompanying the group responsible for any accident or injury to my child/ward.

In the event my child/ward causes any property damage or personal injury, whether individually or in concert with other persons or entities, I/we agree to indemnify and hold harmless the LCSB, its agents and employees.

I/We have read all the information in regards to this trip. I/we are aware of guidelines of said trip and the number of chaperones which will accompany my/our child/ward.

I/We hereby grant permission to the attending physician or his consulting physicians, to render to my/our child/ward any emergency treatment, medical or surgical care that might be deemed necessary to the health and well-being of said child/ward. Also, when necessary for the administering of such care, I/we grant permission for hospitalization at an accredited hospital.

I/We assume full responsibility and liability for any and all expenses, damage, accident, illness, injury or medical expense of and to my/our child/ward or my/our property resulting from such participation. I/We attest and affirm that the participant has no limitation that should prevent participation in the activity and I/we have not been advised or informed by anyone to the contrary.

I/We further agree to inform the appropriate school official(s) should my/our child/ward's physical condition change in any way and any time so as to affect his/her participation in the activity herein named.

I/We further relieve and release said LCSB from any liability in its failure to carry insurance upon my/our said child/ward.

Our/My child/ward has medical insurance _____ Yes _____ No If yes, you must complete and attach a copy of proof of insurance to this form.
Insurance Co _____ Policy # _____

_____ _____ _____ _____
Home Phone Work Phone Cell Phone Emergency Phone

_____ _____ _____ _____
Parent/Guardian Name (Please Print) Parent/Guardian Name (Signature) Date Home Address / City / Zip

THIS SECTION MUST BE COMPLETED BY PARENT/GUARDIAN ONLY IF CHILD/WARD IS GOING OUT-OF-STATE OR OVERNIGHT

_____ (SIGN IN PRESENCE OF A NOTARY)

Parent/Guardian Signature

NOTARY STATEMENT STATE OF FLORIDA, COUNTY OF LAKE

On _____ before me personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the instrument and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal _____

One copy must be retained by the administration and a duplicate copy must accompany the sponsor when leaving school property with student

LAKE COUNTY SCHOOLS

ADMINISTRATION OF PRESCRIPTION MEDICATION CONSENT FORM

Medications must be brought to school by the parent; NEVER by the student. The medication must be presented to school personnel in the original container with a current date. **Metered inhalers should have the label affixed to the inhaler for easy identification or must be in the original box with prescription label.** The parent must give the first dose of prescription medication at home. Under no circumstances will the school accept more than a four-week (30 days) supply of prescription medication. Parents may request that the pharmacist dispense two labeled bottles for medication, one for home and the other for school.

Student _____ DOB _____

Parent _____ School _____

Address _____

Home Phone _____ Work _____

Name of medication _____

Dosage to be given _____ Time to be given _____

Diagnosis _____ Allergies _____

Date to start _____ Last date to be given _____

Please circle one: ☐ **may** ☐ **may not** carry and use the inhaler himself/herself.

Special instructions on administration of medication (i.e. to be given after lunch, do not chew, to be given with food, etc.)

_____

Reaction(s) that may occur _____

_____

I request Lake County Public School personnel to administer medication as directed by this authorization. If there are questions regarding this medication I authorize the School Nurse/District Nurse to contact ordering physician as needed throughout the school year.

It is the parent's responsibility to pick up medications that are no longer needed at school. Medications that have expired and/or are discontinued during the school year will be disposed of within a week of the expiration or discontinuation date. At the end of the school year left over or unused medications will be disposed of immediately after the last day of school.

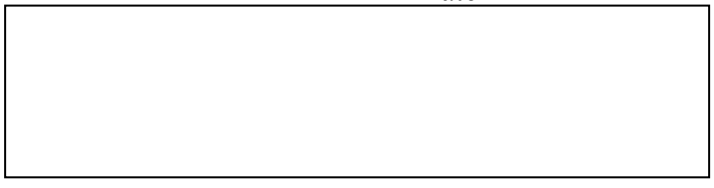
_____ _____

Parent Signature Date

_____ _____

Physician Signature Date

Physician's Official Stamp



LAKE COUNTY SCHOOLS

ADMINISTRATION OF NON-PRESCRIPTION MEDICATION CONSENT FORM

Non-prescription medication may be administered at school by school personnel when such medication is necessary for school attendance and cannot otherwise be accomplished. The non-prescription medication may be administered for 72 consecutive hours, once in the school year. Medication must be brought to school by parent/guardian in a sealed, unopened container. A form must be completed for each medication administered.

Student Name _____ DOB _____

Parent/Guardian _____ Phone _____

Address _____ Emergency Phone _____

Name of non-prescription medication _____

Dose to be given _____ Time(s) to be given _____

Diagnosis _____ Allergies _____

Purpose/reason for this medication _____

Discontinue date _____

Instruction(s) (i.e. take with water, milk, food) _____

What reaction(s) may occur, if known? _____

I request Lake County Public School personnel administer medication as directed by this authorization.

A doctor's signature is required if:

- A medication is necessary beyond the 72 consecutive hours
  or
- When medication needs to be taken on Field Trips

If there are questions regarding this medication I authorize the School Nurse/District Nurse to contact ordering physician as needed throughout the school year.
It is the parent's responsibility to pick up medications that are no longer needed at school. Medications that have expired and/or are discontinued during the school year will be disposed of within a week of the expiration or discontinuation date. At the end of the school year left over or unused medications will be disposed of immediately after the last day of school.

Signature of Parent/Guardian **(REQUIRED)** _____ Date _____

Physician signature (**REQUIRED**) _____ Date _____

Physician's Official Stamp

MOUNT DORA HIGH SCHOOL BAND

Student/Parent Information Form 2023 - 2024

Student Name_____

Instrument_____-_____Grade_____

Home address:_____

City:_____State:_____Zip Code:_____

Home Phone #:_____

Student Cell Phone#_____

Parent Names:

Mom_____Cell:_____

Work:_____

Dad_____Cell:_____

Work:_____

Student Email:_____@_____

Mom Email:_____@_____

Dad Email:_____@_____

School Instrument Rental Needed: yes_____ no_____ $50 Fee/year

Personal Instrument(s): _____

Instrument, Brand, Serial Number

_____

Instrument, Brand, Serial Number

Emergency Contact: (other than parents) _____

Phone:_____ Relationship:_____