




## **2020-2021 Registration**

**Both Online and In-Person Registration must be completed.**

### **Online Registration – Complete by May 31<sup>st</sup>**

Step 1 – Go to the band website [www.vmhsband.com](http://www.vmhsband.com)

Step 2 – Click on the icon  at the top of the page.

Step 3 – Enter our school code “vmhsband”.

Step 4 – Enter your Charms Login Information. **New Students** – Your Charms ID # is listed at [www.vmhsband.com](http://www.vmhsband.com) (Resources – Membership & Registration – Charms ID#). **Returning Members** – Use your existing login information.

New Students – Charms will prompt you to create your password (remember this password!)

Step 5 – Click on “Update Info” and enter your information. Click on the green update button to save information.

### **In-Person Registration – July 13<sup>th</sup> and 14<sup>th</sup>**

Step 1 – Complete (**type in**, don't handwrite) and then **PRINT** this 2020-2021 Registration Packet.

Step 2 – Turn in your completed registration packet, along with your donation at In-Person Registration (see the Donation Schedule and Information link at [vmhsband.com](http://vmhsband.com))

**Juniors & Seniors** - Monday, July 13<sup>th</sup> 7-9pm @ VMHS Performing Arts Center

**Freshmen & Sophomores** - Tuesday, July 14<sup>th</sup> 7-9pm @ VMHS Performing Arts Center



## 2020-2021 Member Registration Forms

(Please type in and print forms/do not handwrite)

Check All That Apply:		New	Returning
Marching	Color Guard	Concert	Jazz
Last Name:		First Name:	
Address:			
City:		Zip:	
Home Phone:			
Date of Birth:		Gender: Male	Female
Instrument or Unit:		Second Instrument:	
Grade for Next School Year:	9	10	11 12

### Parent Information

Mother's Name:	Father's Name:
Address:	Address:
Occupation:	Occupation:
Daytime Phone:	Daytime Phone:
Cell Phone:	Cell Phone:
E-Mail:	E-Mail:

## **EMERGENCY MEDICAL TREATMENT AUTHORIZATION TO SECURE**

To Whom It May Concern: If neither of the parents can be contacted in the case of a serious injury or illness, I/We hereby authorize representatives of Vista Murrieta High School or members of the VMHS Band Boosters to act as my/our agent to secure emergency treatment for the student named below, a minor child for who I/We are responsible for during the time when the student below is attending or participating in band related activities and functions. I/We further agree to hold Vista Murrieta High School, the School District, the VMHS Band Boosters, and its representatives, harmless for exercising its judgment in authorizing such emergency treatment, and said representatives are specifically authorized to sign any required emergency hospital treatment forms on my/our behalf.

### **OVER-THE-COUNTER MEDICATION LIST**

I give permission to the VMHS Band staff and the VMHS Band Boosters to provide for my child the following OTC medications, and or treatment, to be offered at their discretion. Please check any medications that may be given:

Acetaminophen - Tylenol	Ibuprofen – Advil-Motrin-Aleve
Tums	Antacid – Pepto-Bismol
Premenstrual Tablet - Midol	Decongestant – Sudafed
Antihistamine - Benadryl	Cough Drops / Throat Lozenges
NO OTC MEDICATION to be given	

Student Name: \_\_\_\_\_

Student DOB: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

# MEDICAL TREATMENT AUTHORIZATION FORM

So that we may properly discharge our responsibilities for your child's welfare, it is mandatory, and a condition of your child's membership with the band, that this form be filled out completely, signed and dated by at least one parent or guardian. In case of a serious accident or illness, it is imperative that school personnel or members of the band boosters be aware of any serious medical conditions, and are able to quickly reach a parent or guardian.

## STUDENT IDENTIFICATION

Name	Grade
Address	DOB
Phone	

### FAMILY INFORMATION in Case of Emergency

Mother's Name	Father's Name
Mother's Employer	Father's Employer
Mother's Wk #	Father's Wk #
Mother's Cell #	Father's Cell #
Neighbor/Relative	Phone
Neighbor/Relative	Phone
Family Physician	Office #
Health Insurance Carrier	Policy ID#
Name of Insured	Group #

## STUDENT MEDICAL INFORMATION

All health problems of the above named student, past and present, which may limit physical activity and /or be aggravated or worsened by physical activity, and/or which should be known in the treatment of an illness or injury MUST be known. Please check below if the above named student has or has had any of the following:

Chronic Knee Problems	Bee Stings	Hyperventilation
Chronic Ankle Problems	History of Epilepsy	Heart Related Problems
Chronic Back Problems	History of Diabetes	Chronic Cough
Chronic Foot Problems	GI Disorders/Problems	Food Allergies
Metabolic/Thyroid Disorders	Drug Allergies	Asthma
Other	Other	Non Known

**If any of the above items have been checked, please provide an explanation on back.**

**VOLUNTARY EXCURSION / FIELD TRIP PERMISSION  
AND MEDICAL AUTHORIZATION – MULTIPLE TRIPS  
2020 - 2021**

Dear Parent / Guardian:

I hereby authorize (student's name) \_\_\_\_\_ to participate in voluntary off-campus field trips/excursions. These may include, but are not limited to, trips to government facilities, parks and zoos, athletic events, conferences and meetings, local businesses, entertainment events, exhibitions and fairs, museums and cultural centers, etc.

It is extremely important to be aware of any medical condition/problem and /or medications a student is required to take when going on a field trip. Please list any medical conditions and/or medications that we should know about on the medical forms provided.

Any student who needs to take medication while on a field trip **MUST** have written permission from both the parent and the physician, as well as provide the medication in the original, labeled, container. A staff person must keep the medication with them at all times unless previous arrangements have been made (i.e.: student has written permission on file to carry medication, such as asthma inhaler).

<b>**Fill out this section ONLY IF student needs to take medication during field trip**</b>		
Medication:	Dose:	Time(s) of Administration:
Physician Signature:	Date:	Phone #:

In the event of illness or injury, I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

**As stated in California Education Code Section 35339, I agree to hold Murrieta Valley Unified School District, its officers, agents and employees harmless from any and all liability or claims which may arise out of or in connection with my child's participation in this activity.**

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip. Any violation of these rules and regulations may result in that individual being sent home at the expense of his/her parent /guardian.

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ DOB: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Subscriber's ID#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone : \_\_\_\_\_



## ACH / Credit Card Donation Authorization

Recurring Charge – You authorize regularly scheduled charges to your Credit Card or Bank Account. You will be charged the amount indicated below each billing period. The charge will appear on your Credit Card or Bank Account Statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I \_\_\_\_\_ authorize Vista Murrieta Band Boosters to debit my Credit Card or Bank Account below for \$\_\_\_\_\_ beginning on \_\_\_\_\_ (Date) for \_\_\_\_\_ months.

Donation for: \_\_\_\_\_

Billing Address \_\_\_\_\_ Phone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the merchant may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$35.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

**Individual's Signature** \_\_\_\_\_ Date \_\_\_\_\_

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**After transaction is input into merchant processing service - this portion of form will be shredded.**

### Credit Card Information

- Visa  - MasterCard  - AMEX  - Discover

Cardholder's Name - \_\_\_\_\_

Credit Card Number - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date - \_\_\_\_/\_\_\_\_ Security Code (CVV) - \_\_\_\_