

Jackson Memorial Band Parents, Inc.

2016-2017 Membership

PO Box 800,
Jackson, New Jersey 08527
732-833-1333

___ \$5 Individual Member

___ \$10 Family Membership

___ \$3 Individual Alumni

___ \$5 Family Alumni

Band Member(s) & Class Year

Band Parent Member(s)

Address

Phone

E-Mail

Payment by **check only** payable to:

Jackson Memorial Band Parents, Inc.

Please submit a separate check for each form.

Benefits of Membership are listed in the Parent Handbook.

Check# _____

Amount \$ _____

Date _____

**BAND/COLOR GUARD CONTRACT FOR
2016-2017 SCHOOL YEAR
(Please sign and return)**



(Student's Last Name Initial)

I have read and understand the material contained in the band hand book, especially the areas concerning the assessment, band rules and regulations, the grading and award system. I realize the band program goes beyond the classroom in its scope. Therefore, my responsibilities are greater than they would be in a standard classroom situation. This band manual represents a source of information and a contract. I agree to accept the responsibilities and rewards as a member of the band program. I acknowledge and agree if I fail to comply with the rules and regulations it may result in disciplinary action and/or removal from the band program.

I understand that I am responsible for my uniform, my instrument and my personal belongings. I may not hold the Jackson Memorial Band Parents, Inc. responsible for the loss of any of these items while at football games, competitions or trips. I am also responsible for any instrument or item belonging to the Jackson Memorial Band (rifles, flags, uniforms, instruments, etc.) If any such item is lost or damaged, I understand that I am responsible for the cost to repair and/or replace that item.

ACCEPTED AND AGREED:

Print Name of Student _____ Signature of Student _____

Print Name of Parent or Guardian _____ Signature of Parent or Guardian _____

Parent e-mail _____

Home address _____

Parent Home Phone # _____ Parent Cell # _____

(Please indicate which number you prefer for phone chain: ____ HOME ____ CELL)

Student Cell # (for section leader) _____

Student Email (for section leader) _____

Instrument _____ serial# _____

OWNED BY STUDENT _____ OWNED BY SCHOOL _____

Condition of Instrument owned by School: _____ Initials _____

CHECK HERE IF YOU ARE A COLOR GUARD MEMBER _____

MEDIA RELEASE FORM 2016-2017



(Student's Last Name Initial)

Dear Parent/Guardian:

During the year The Jackson Memorial High School Communications Department, Jackson Memorial Band Parents, Inc. and local media representatives write stories that feature newsworthy events and student achievements within our educational community.

Photographs and video footage are taken by band parents, JHMS Communications Department and by news media, such as the *Asbury Park Press*, *The Jackson Times*, *Tri-Town News*, *J-TV* and *Star Ledger* and on social media (*Facebook*, *Twitter* etc.) Broadcast media including network and cable television news programs are also on site for various events.

Please complete the permission form below to indicate whether you grant the Jackson Memorial Band Parents, Inc., Jackson School District and/or New Jersey Education Association (NJEA) and/or news media permission to photograph or videotape your child for band publicity, district publicity and/or media publications.

If this form is not returned, your child will NOT be allowed to be photographed and/or videotaped for district or media publications.

Please **print** all information

Student's Name _____

Grade _____

Parent/Guardian Name (Printed) _____

Parent/Guardian Signature _____

The Jackson School District/media may photograph and/or videotape my child to highlight school news and events: YES NO

JACKSON SCHOOL DISTRICT
Permission for Trips



My Child _____ (Student's Last Name Initial) has my permission to participate in: Marching Band of Jackson Memorial High School for the 2016-2017 school year including all competitions and performances with the band directors, Jason Diaz and Eric Ficarra including, but not limited to all football games, parades, community events, competitions, championships, etc. from September 1, 2016 through June 30, 2017.

This is to certify that my child, named above, has my permission to participate in the specified trip(s), and to travel off school grounds with the group for the purpose of participating in the group's activities and events. I understand that, if circumstances warrant, including in case of disciplinary infractions, I may be contacted and requested to transport my child home prior to the end of the trip(s). I understand, further, that a separate consent form will be provided in the event the activities of the group will involve overnight and/or out-of-state travel.

I knowingly and voluntarily agree to waive any and all claims for liability, loss, injury damages, or expenses which my child and I may have against the Jackson Township Board of Education, collectively and individually, and its agents, employees and chaperones resulting in any way from participation in the above activity and related transportation.

STUDENT TRIP MEDICAL RELEASE AND HEALTH INFORMATION

In case your child may require emergency medical services while on an off-campus trip, we ask that you complete the following information. In the event that medical attention becomes necessary, it should be understood that if this information is not completed, treatment may not be rendered.

Parent/Guardian Name _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____

If Parent/Guardian cannot be reached, in case of emergency, please call:
Name: _____ Phone#: _____
Relationship: _____
Family physician name: _____ Phone#: _____
Health Insurance Name: _____ ID # _____
Student's Date of Birth: _____

Any health factors/medical conditions, known allergies of which chaperones should be aware (please note that this does not include, nor are you required to provide, any information regarding HIV or AIDS):

Medications taken regularly. Please note rescue inhalers, epi-pen, pain relievers (be specific):

I hereby give permission to designated band chaperones and band staff to administer Over the Counter medication as follows (check all that apply)

Analgesics – pain: Acetaminophen _____ Ibuprofen _____ Aspirin _____
Antihistamine – allergy: Diphenhydramine _____
Motion sickness: Dimenhydrinate _____ Meclizine _____

Signature _____

Date _____

Print Parent Name: _____