2023-2024 Registration Packet

Registration Packet – Return at Kick-off Meeting on April 26th

- Step one – Go to our band website www.mmhsperformancecorps.org
- Step two – Click on the INFO, then RESOURCES
- Step three – There will be link for the Registration Packet
    - All new and returning members will need to fill out the packet and print it off.

Setting up your CutTime account for *student* AND *parent*

This program is used for email communication from the director and booster president, to make donation payments, calendar and etc.

- Step one – Go to our band website (www.mmhsperformancecorps.org)
- Step two – Click on the INFO, then CutTime (www.cuttime.net)
- Step three – Click Student/Parent Sign Up
- Step four – Fill in **ALL** information
- Step five – Click on Register now!

Setting up your Band App account for *student* AND *parent*

This app (also web based) is used for reminders, calendars, communication between everyone, post pictures, etc.

- Step one – Go to our band website (www.mmhsperformancecorps.org)
- Step two – Click on the INFO, then Band App (www.band.us/home)
- Step three – Click Sign up
    - Select option you prefer
- Step four – Fill in **ALL** information
- Step five – answer security question and submit

Member Registration Forms

Please type in and print forms, do not handwrite

Check ALL that apply:	New Member	Current Member	
	Band	Color Guard	
Last Name:		First Name:	
Address:			
City:		Zip	
Home Phone:		Cell Phone:	
Date of Birth:		Gender: Male	Female
Instrument:		Second Instrument (if applicable)	
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:
Email:	Email:

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 Murrieta Mesa High School or members of the MMHS 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 Murrieta Mesa High School, the School District, the MMHS 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 MMHS Band staff and the MMHS 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:

Acetaminophem – 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 IDENTIFICATION 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		Non-Known
Explanation:		

Murrieta Valley Unified School District

VOLUNTARY EXCURSION/FIELD TRIP PERMISSIONAND MEDICAL AUTHORIZATION – MINOR

To be completed by parent/guardian and collected/maintained by teacher / trip organizer

Dear Parent/Guardian:

Kindly complete and return this form to ____
(teacher / person in charge of trip)

I hereby authorize (*student's name*) ________________________________ to participate in the following activity:

Description (e.g.; "*Field trip*"): ____________________ Destination: ______________________________

Departure date: ______________________________ Return date: __________________________

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.

______________________________________ ______________________________________
Medical Condition/Severe Allergies Treatment/Limitations

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 (ie: student has written permission on file to carry medication, such as an asthma inhaler).

***** Have your physician fill out this section ONLY if student needs to take medication during field trip *****

________________________________ ________________ ___________________________
Name of Medication Dose Time(s) of Administration

________________________________ ________________ ___________________________
Physician Signature Date Phone Number

*If your student already has medication at school that they take on a daily basis, you may contact the Health Office and arrange, ***prior to the field trip***, for their medication, along with the permission forms to be sent on the field trip. **If you do not contact the Health Office, it will be assumed they will not be taking their medication unless you make other arrangements.**

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 judgement 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 35330, 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.

By my signature below, **I acknowledge the highly contagious nature of COVID-19 and voluntarily assume the risk** of becoming exposed to or infected by COVID-19 and accept sole responsibility for any injury to my child(ren), myself or my family (including, but not limited to, personal injury, disability, and death) and shall defend, indemnify and hold harmless the Murrieta Valley Unified School District, its Board, officers, agents and employees against any and all claims, demands, losses, damages, court costs, attorney fees, expenses, or costs of any kind or character, as it relates to COVID-19.

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: ________________________

____ Student's Birth date:________________

Medical Insurance Carrier: ______________________ Subscriber's ID #: ________________

Emergency Contact: ________________________ Phone: ________________________

Credit Card Donation Authorization

Donations can also be made through the CutTime Website!

Recurring Donation – You authorize regularly scheduled donation to your Credit Card or Debit Card. You will be donating the amount indicated below each cycle. The donation 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 donation being collected.

I _______________ authorize Murrieta Mesa High Band Boosters to debit my Credit Card below of $______ beginning on ________(Date) for _______ months.

Donation for: _____________________________________ (Name of Card/Account)

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 ______________

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

Credit/Debit Card Information

___ - Visa ___ - Master Card ___ -AMEX ___ -Discover

Cardholder's Name - ____________________________

Card Number - ______ - ______ -______ -______

Expiration Date - __/___ Security Code (CW) _____