

2019 – 2020 Band and Show Choir Emergency Medical Authorization Form

Student _____ Grade in 2019 – 20 _____

Address _____ Phone _____

Mother's Name _____ Phone _____

Email _____ Email _____

Father's Name _____ Phone _____

Email _____ Email _____

Alternate Contacts: (In a medical emergency, we will contact these individuals if neither parent can be reached)

Name _____ Relation _____ Phone _____

Email _____ Phone _____

Name _____ Relation _____ Phone _____

Email _____ Phone _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medication conditions which the school or emergency physician should know. _____

Medications are to be placed inside a plastic zip lock bag labeled with your child's name and should be brought to the camp by parents. Children are NEVER to transport medications. All medications, including prescription and OTC meds MUST be accompanied by a physician's signed orders and include dose instructions. NO EXCEPTIONS. OTC medications include aspirin, Tylenol, cough drops, etc. If your child requires an inhaler, please request a form.

Purpose: To enable parents or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Daytime Phone _____

Dentist _____ Daytime Phone _____

Medical Specialist _____ Daytime Phone _____

Local Hospital _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted: _____

Signature _____ Date _____

Refusal to Consent

I do NOT GIVE my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Signature _____ Date _____