

FORM #1: EMERGENCY MEDICAL AUTHORIZATION FORM



PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians can not be reached. This form is necessary for students to travel on any band trip through July 30, 2011. Please complete **both sides** of the sheet and **PRINT** all information.

STUDENT INFORMATION:

STUDENTS NAME _____ Age _____ Grade _____
Last First Middle

HOME TELEPHONE: () _____ Date of Birth _____

ADDRESS _____ LEGAL CUSTODY is held by (circle)____
Street Father Mother Joint
City State Zip other _____

STUDENT'S CELL PHONE NUMBER () _____

PARENT/GUARDIAN INFORMATION:

FATHER'S / GUARDIAN'S FULL NAME _____

ADDRESS _____

HOME PHONE NUMBERS _____ CELL PHONE NUMBER _____

EMPLOYER _____ WORK PHONE NUMBER _____

MOTHER'S / GUARDIAN'S FULL NAME _____

ADDRESS _____

HOME PHONE NUMBERS _____ CELL PHONE NUMBER _____

EMPLOYER _____ WORK PHONE NUMBER _____

NAME OF INSURANCE COMPANY: _____ Phone _____

POLICY / GROUP NUMBER _____

PERSON TO CONTACT IF UNABLE TO REACH PARENT/GUARDIAN:

NAME _____ RELATION TO STUDENT _____

HOME ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OVER THE COUNTER MEDICATION DISPENSATION:

The band nurse and/or designated chaperones will have over-the-counter medications (for colds, upset stomach, headache, travel sickness, etc) available for students at their request. Please place an "X" in the box which indicates your intentions, then sign the appropriate line. NOTE: Aspirin is never dispensed to a student.

Do you wish for your child to receive these medications if needed?

YES _____ NO _____ PARENT/GUARDIAN SIGNATURE: _____ DATE _____

ANY MEDICATIONS THAT SHOULD NOT BE DISPENSED? _____

MEDICAL INFORMATION ON THE STUDENT

Student's Name _____

The following information is needed by any hospital or practitioner not having access to the student's medical history.

ALLERGIES: _____

(Include allergies to Food, Animals/Insects, Environmental)

NOTE: Students with allergies to bee stings should provide the band nurse/designated chaperone with a bee sting kit. This kit will be included with the first aid equipment for the duration of the band season..

ALLERGIES to MEDICINE (or Drugs): _____

PAST PERTINENT MEDICAL HISTORY _____

CURRENT MEDICAL CONDITIONS or MEDICAL DIAGNOSIS: (chronic injuries, major surgery, etc.) _____

DAILY MEDICATIONS: Needed as of today. Updates to this form will be made before we depart.

Name of Medication

Dosage

Time of Day

STUDENT HAS A PRESCRIPTION (as listed above) & IS PERMITTED TO CARRY ON HIM/HER :

___ Epi Pen (bee stings)

___ Inhaler (asthma)

Parent signature _____

these are the only 2 medications that students may have in their possession.

PHYSICAL LIMITATIONS _____

DATE OF LAST TETANUS _____ **CONTACTS WORN?** Y N (Hard Soft)

DIET LIMITATIONS _____

FAMILY PHYSICIAN _____ **PHONE** _____

FAMILY DENTIST _____ **PHONE** _____

MED. SPECIALIST & SPECIALTY _____ **PHONE** _____

LOCAL HOSPITAL _____

----- Please read and sign **ONE** of the two lines -----

TO GRANT CONSENT FOR TREATMENT

I hereby give my consent, in the event that all reasonable attempts made to contact me at my home or my place of employment have been unsuccessful, for the administration of treatment deemed necessary by a licensed physician or dentist, and the transfer to any hospital or emergency care facility reasonably accessible. This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

SIGNATURE OF PARENT/GUARDIAN: _____ **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 actions:

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE** _____ (revised: 7/ 2009)