STUDENT MEDICAL/SURGICAL AUTHORIZATION & CONTACT FORM

Please Print * Please Print * Please Print * Please Print * Please Print * Please Print * Please Print * Please Print * Please Print * Please Print

First Name ____________________________________ Last Name ___________________________________

Street Address ____

City ____________________________________ State__________________ Zip_________________________

Social Security # __________________________ Date of Birth ______________ Age ______ Grade _________

Is the student allergic to any medication and/or food? _______ Which? __________________

Is the student allergic to bee stings?_____ If yes, does he/she carry their own kit?_________

In case of sickness, may this student take: Aspirin? ___ Ibuprofen?___ Tylenol? ___ Imodium AD?___ Pepto Bismol?___

Does this student wear contact lenses? _______________ Prescription glasses?_____________

Does this student suffer from: Hay fever _________ Allergies ______________ Asthma __________

Does this student take any medication? _________ Which? _______________________________________

Any other health history that may assist the person in charge should this student become ill?

FIRST CONTACT IN CASE OF EMERGENCY:

Parent/s or Guardian/s Name/s ____

Address ____

City ____________________________________ State_____________________ Zip________________________

Phone 1 (Home) ________________________________ Phone 2 (Work) _______________________________

Phone 3 (Cell) ________________________________ Phone 4 _______________________________

FAMILY PHYSICIAN

Name________________________________ Phone _____________________ Other Phone ___________________

OTHER EMERGENCY CONTACT(S) - *OPTIONAL*

Name_________________________ Relationship ________________________ Telephone ______________________

Name_________________________ Relationship ________________________ Telephone ______________________

Name_________________________ Relationship ________________________ Telephone ______________________

WE DO [ ] WE DO NOT [ ] HAVE HEALTH OR ACCIDENT INSURANCE

Insurance Company Name ____

Group Number ______________________________ Policy Number of Group ______________________________

We have attached a copy of our Insurance card to this form: YES [ ] NO [ ]

The student carries their own insurance card with them: YES [ ] NO [ ]

This form has been filled out to the best of my knowledge. I hereby authorize medical or surgical treatment of _____________________________________ in the event of any emergency, illness or accident. I accept all responsibility and liability for any occurrence during this student's participation with the band. *I further agree to be available during band trips at one of the numbers listed above or ensure that an alternate means of contact is written on this form BEFORE any trip.*

____ ______________________________

Signature of Parent(s) or Guardian(s) Date