GREAT FALLS HIGH SCHOOL BAND, GREAT FALLS, SC

2008 – 2009 CONSENT FOR MEDICAL TREATMENT

TO WHOM IT MAY CONCERN, I, the undersigned parent or guardian of:

Name of Student ______________________________ Date of Birth ___/___/19___

Hereby grant authorization to the Band Director or any chaperone of the Great Falls High School Band Boosters standing in loco parentis, to obtain any emergency medical and/or surgical procedures from a physician or hospital emergency room physician on behalf of the above named minor.

Parent Signature ____Date ___/___ /_____

Parent's Printed Name ____

Notary ____

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GENERAL INFORMATION

Student ____ Home Phone (____) _____ - _______

Address ____

City ____ State _____ Zip Code _________

Father's Name ____ Bus. Phone (____) _____ - ________

Place of Business ____ Title ___________________________

Mother's Name ____ Bus. Phone (____) _____ - ________

Place of Business ____ Title ___________________________

ALTERNATE TO NOTIFY IN CASE OF EMERGENCY

Name ____

Relationship ____ Phone (____) _____ - ________

City ____ State _____ Zip Code _________

FINANCIAL CONSIDERATIONS

For and in consideration of emergency services and goods rendered by or through the attending physician(s), the undersigned hereby guarantees payment in full, immediately upon receipt of the final billing.

Signature ____ Date ___/___ /_____

GREAT FALLS HIGH SCHOOL BAND, GREAT FALLS, SC

2008 – 2009 MEDICAL INFORMATION FORM

Name of Student ____

Sex: Male _____ Female _____ Date of Birth ___/___/19___

Health Insurance Carrier: ____

Parent: _________________________________ Policy #____________________

PLEASE COMPLETE THE QUESTIONS BELOW. It is imperative that we have medical information in order that we may care for the student in case of emergency.

1. Does the student have chronic health problems? Yes _____ No _____
   If yes, please explain:
   ____
   ____

2. Is the student allergic to any medicines? Yes _____ No _____
   If yes, please explain:
   ____
   ____

3. Does he/she have allergies? Yes _____ No _____
   If yes, please explain:
   ____
   ____

4. Is he/she currently taking any medications? Yes _____ No _____
   If yes, please explain:
   ____
   ____

5. What is the date of the student's last tetanus shot? Date ___/___ /_____

6. Please provide any additional pertinent information.
   ____
   ____

Family Physician Name: _____________________________________ Phone (____) _____ - _______

Address: ____

In case of minor illness, the Great Falls High School Band Director or chaperones of the Band Boosters have my permission to give over-the-counter drugs such as Tylenol, Maalox, Sudafed, Ibuprofen or Dramamine to my son / daughter. Yes _____ No _____