Tri-Valley High School Band
Emergency Medical Authorization
20___ - 20___

(PLEASE PRINT)

STUDENT:_____
BIRTHDATE:_____**AGE:**____ **SEX:**___
GRADE:_____ **HOME PHONE #:**_____
ADDRESS:_____
CITY:_____ **ZIP CODE:**_____

MOTHER'S NAME:_____
PLACE OF WORK:_____
WORK PHONE #:_____

FATHER'S NAME:_____
PLACE OF WORK:_____
WORK PHONE #:_____

List three other emergency contacts:

1._____
Phone #:_____ Relationship:_____
2._____
Phone #:_____ Relationship:_____
3._____
Phone #:_____ Relationship:_____

Is student covered by health insurance? YES ___ NO ___ **(Attach a copy of your insurance card or claim form.)**
Are immunizations up-to-date? YES ___ NO ___ If not, please explain:_____
Date of last tetanus booster: _____

List any medical problems (allergies, diabetes, epilepsy, asthma, etc., or disabilities):

_____

DRUG ALLERGIES: _____
FOOD ALLERGIES: _____
DIET RESTRICTIONS: _____

MEDICATIONS STUDENT IS CURRENTLY TAKING: _____

OTHER PERTINENT FACTS TO WHICH A PHYSICIAN SHOULD BE ALERTED: _____
_____

PARENTAL CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:
PHYSICIAN: _____ PH #: _____ MEDICAL SPECIALIST: _____ PH #: _____
DENTIST: _____ PH #: _____ LOCAL HOSPITAL: _____ PH #: _____

PARENT's MEDICAL STATEMENT

(Student's Name) _____ has my permission, while attending band functions, to take any over-the-counter medications (**listed below) as needed with the exception of _____.

In the event reasonable attempts to contact me were unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, 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.

*PARENT/GUARDIAN SIGNATURE_____ DATE: _____

**NOTARY SIGNATURE & SEAL_____ DATE:_____

* THIS MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC. (THERE IS USUALLY ONE PRESENT AT THE MEETING.)

** These are some of the medications routinely stocked in our first aide supplies and dispensed free of charge on an as needed basis.
ORAL: Non-aspirin pain reliever, Gas-X, Robitussin cough syrup, Emetrol (nausea), Benadryl, Kaopectate/Imodium AD, Dimetapp extentabs, Maalox, Chlor-Trimeton tablets, Advil, Pepto-Bismol, and Rolaids/Tums.
TOPICAL: BenGay, suntan lotion, medicated body powder, antibiotic cream, hydrocortisone cream, corn starch, Desenex, and Epsom salts. Name brand, generic brand, and store brands are used.