

# John T. Hoggard High School Band

## MEDICAL TREATMENT AUTHORIZATION FORM

So that we may properly discharge our responsibilities for your child's welfare, it is mandatory, and a condition of your child's membership with the band, that this form be filled out completely and signed and dated by at least one responsible parent or guardian. In case of a serious accident or illness, it is imperative that school personnel be aware of any serious medical condition and be able to quickly reach a parent or guardian.

### STUDENT IDENTIFICATION

NAME \_\_\_\_\_ GRADE 2009-2010 \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
PHONE \_\_\_\_\_

### FAMILY INFORMATION in CASE of EMERGENCY

Father's Name \_\_\_\_\_ Father's Employment \_\_\_\_\_  
Father's Work Phone \_\_\_\_\_ Father's cell phone/pager \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Mother's Employment \_\_\_\_\_  
Mother's Work Phone \_\_\_\_\_ Mother's cell phone/pager \_\_\_\_\_  
Family Physician \_\_\_\_\_ Office phone \_\_\_\_\_  
Neighbor/Relative Name \_\_\_\_\_ Phone \_\_\_\_\_  
Neighbor/Relative Name \_\_\_\_\_ Phone \_\_\_\_\_  
Health Insurance Carrier \_\_\_\_\_ Policy ID # \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Group # \_\_\_\_\_

### STUDENT MEDICAL INFORMATION

All health problems of the above named student, past and present, which may limit physical activity and/or be aggravated or worsened by physical activity, and/or which should be known in the treatment of an illness or injury MUST be known. The appropriate personnel will hold all students' medical information in strict confidence. Please check below if the above named student has or has had any of the following:

<input type="checkbox"/> Chronic Knee Problems	<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Hyperventilation
<input type="checkbox"/> Chronic Ankle Problems	<input type="checkbox"/> History of Epilepsy	<input type="checkbox"/> Heart Related Problems
<input type="checkbox"/> Chronic Back Problems	<input type="checkbox"/> History of Diabetes	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Chronic Foot Problems	<input type="checkbox"/> GI Disorders/Problems	<input type="checkbox"/> Other
<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Metabolic/Thyroid Disorders	<input type="checkbox"/> None
<input type="checkbox"/> Drug Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> USES INHALER

If any of the above items have been checked, please provide a complete explanation. Attach a separate piece of paper if needed.

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**AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT**

TO WHOM IT MAY CONCERN: If neither of the parents can be contacted in the case of a serious injury or illness, I/We hereby authorize representatives of Hoggard High School/New Hanover County Schools to act as my/our agent to secure emergency treatment for the above named student, a minor child for whom I/We are responsible, at an appropriate medical facility during the time when the above named student is attending, coming to or leaving school or participating in band related activities and functions. I/We further agree to hold Hoggard High School/New Hanover County Schools and its representatives harmless for exercising its judgment in authorizing such emergency treatment, and said representatives are specifically authorized to sign any required emergency hospital treatment forms on my/our behalf.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**OVER-THE-COUNTER MEDICATION LIST**

I give my permission to the band chaperones to provide for my student the following OTC medications and or treatments to be offered at the chaperones discretion or by my directions below: Please check if medications may be given:

- Acetaminophen i.e. Tylenol Adult Dosage other instructions \_\_\_\_\_
- Dramamine (Motion Sickness) Adult Dosage other instructions \_\_\_\_\_
- Pepto Bismal Adult Dosage other instructions \_\_\_\_\_
- Immodium-D Adult Dosage other instructions \_\_\_\_\_
- NO OTC Medications

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I understand no OTC medications will be offered to my student if I have not given my consent no matter the degree of discomfort.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_