

**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 the supervision of the band staff, when parents or guardians cannot be reached.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

**IN CASE OF EMERGENCY WHEN THE ABOVE CANNOT BE REACHED**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**HEALTH HISTORY**

**Check if yes:**

Asthma       Fainting Spells       Convulsions       Diabetes  
 Heart Trouble       Allergy or reaction to any medication       Swimming or Sports Restrictions  
 Other – describe this or above \_\_\_\_\_

None apply – please check: \_\_\_\_\_

Currently under a doctor’s care Yes \_\_\_\_\_ No \_\_\_\_\_ Describe \_\_\_\_\_

**Have difficulty with the following:**

Eyes, Ears, Nose, Throat       Problem with feet  
 Menstrual Problems       Back Problems  
 Digestion       Bed wetting  
 Sleepwalking       Lungs  
 Exposure to sunlight/sunburn

Condition requiring regular medication (over the counter and/or prescription) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and type (keep in original bottle) \_\_\_\_\_

Any medical restrictions of activity \_\_\_\_\_

Explain \_\_\_\_\_

Immunizations: Tetanus toxoid \_\_\_\_\_ Any special immunizations \_\_\_\_\_

**INSURANCE INFORMATION**

Medical Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_  
ID Number \_\_\_\_\_ Policy Number \_\_\_\_\_ Plan Code \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Relationship of Subscriber \_\_\_\_\_

**PART I: TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Physician: \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone \_\_\_\_\_  
Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Hospital \_\_\_\_\_ Phone \_\_\_\_\_

I understand that marching band does require physical activity which includes running laps, marching and standing at attention for long periods of time. I also understand that if I am in doubt as to whether or not my child is physically capable of doing these band activities, that I should have a complete physical done for my child. The Lancaster City School Board recommends that each student receive such a physical.

In the event that reasonable attempts to contact me are unsuccessful, I hereby give my consent for 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 the transfer of the child to any hospital reasonably accessible.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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**PART II: REFUSAL TO CONSENT**

I **DO NOT** give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the band staff to take the following action: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that marching band does require physical activity which includes running laps, marching and standing at attention for long periods of time. I also understand that if I am in doubt as to whether or not my child is physically capable of doing these band activities, that I should have a complete physical done for my child. The Lancaster City School Board recommends that each student receive such a physical.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_