Medical Treatment Authorization Form 2009-2010 Band Trips

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(Student's Last Name) *please print* (Student's First Name)

I agree to release the Southington Board of Education, Southington Band Backers and assigned chaperones from any responsibility for injuries incurred by my (son/daughter) during band trips.

Should an emergency situation arise, I hereby give permission to the Band Director to obtain proper medical aid, including hospitalization, for my (son/daughter). I will assume responsibility for all costs relating to such medical attention. Parent/Guardian(s) will be notified as soon as possible. I also authorize Band Director or assigned member of Band Backers to provide transportation for my (son/daughter) for the Medical facility or Paramedic following an emergency in my absence.

My family is covered by the following Medical Insurance:

______________________________ ______________________________

Insurance Carrier Membership Number/Policy Number

Policy Holder's Name: ____

Subscriber (Employer): ____

WHERE PARENTS CAN BE REACHED IN AN EMERGENCY:

____

Home Address Home Telephone Number Cell Phone

____

Father's Place of Business Mother's Place of Business

____

Father's Business Address Mother's Business Address

____

Father's Business Tel. Number Mother's Business Tel. Number

My (son/daughter) is authorized to take the following medications, as prescribed by a physician. (All medication must be carried in the prescription bottle as obtained from the pharmacy with a label that clearly identifies the contents. Unmarked pill boxes or bottles will not be allowed.)

Please list only those medications that are taken on a regular basis.

PLEASE LIST MEDICATIONS:

Pharmacy: Prescriptions (Medications) Physician:________________

____

My (son/daughter) does **NOT** take medication (check, if applicable). _______

My (son/daughter) is allergic to the following medications:

____

Please list any other pertinent health data you feel would help us in the event of a medical emergency (i.e., past history, injuries, etc.). Check any if applicable and explain, if necessary:

______ Back problems _____ Diabetes _____ Other (Explain): ____________________

_______ Scoliosis _____ Cardiac

_______ Epilepsy _____ Asthma

Band Member's Name:______________________________ Date of Birth: ________________

Street Address:____

City, State, Zip:____

Parent signature: ______________________________ Date: ____________________