

Medical Treatment Authorization Form

2010-2011 Band Trips

(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: