

Stony Point High School Band
Consent for Medical Treatment
2008-2009

(Please Print)

I, the undersigned, being the parent, legal next of kin or the legal guardian or

First: _____ Last: _____

Address: _____

City, State, Zip: _____

Home Phone: (512) _____

DOB: _____

Instrument: _____

hereby grant authorization to the Director(s) or any authorized chaperone of the Stony Point High School Band, to obtain any emergency medical and/or surgical treatment and procedures from a physician or hospital emergency room physician on behalf of the above named minor. I also (circle one) **GRANT / DENY** permission to administer over-the-counter medication as needed.

Signature of person giving consent

Date

Parent 1 Name: _____

Parent 2 Name: _____

Parent 1 Work #: _____

Parent 2 Work #: _____

Parent 1 Cell #: _____

Parent 2 Cell #: _____

List all known allergies (food, medications, etc.). If none, so state: _____

List special medical problems. If none, so state: _____

List any medication the student is presently taking and its purpose. If none, so state: _____

Medical Insurance Carrier Information

Insurance Carrier: _____ Policy #: _____

Student Soc. Sec. #: _____ Group/Plan #: _____

Current Physician: _____ Ins. Carrier Phone #: _____

Physician's Phone #: _____

Please attach a photocopy of your medical identification card.

Financial Considerations

If there is no medical insurance coverage, please sign below the following statement:

For and in consideration of emergency services and goods rendered by or through the attending physician(s), the undersigned hereby guarantees payment in full immediately upon receipt of the final billing.

Signature of responsible party: _____

Relationship to student: _____