C

COLONIAL FORGE HIGH SCHOOL BANDS

"THE FORGE SOUND AND GUARD"

STUDENT MEDICAL INFORMATION AND AUTHORIZATION TO TREAT FOR 2011-2012

Please Print Neatly or Complete Electronically

***Student Name*___________________________________ *M F Birth Date*____ /____ /____ *Student ID#* _____________**

I, the undersigned, being the parent or legal guardian of the person named above, hereby authorize any necessary medical treatment for this person while participating in the Colonial Forge High School Music Program. I guarantee payment of all charges incurred for medical treatment (physician, hospital, x-ray, lab, medications, ambulance, etc.). I also give my permission for the above student to participate in all music-related activities for the school year and for the staff or chaperones accompanying the band to give first aid and administer over-the-counter medicines when needed. I encourage this same student to adhere to the policies and rules of the school.

1. Allergies to food, medication, insect bites, etc. (if none, so state) ____

____

2. Special medical problems (if none, so state) ____

____ Has student been prescribed: Inhaler EpiPen

3. Does your student need any special considerations relative to heat, hydration or diet? Dietary concerns should include both cultural and health needs. ____

4. Does student use other prescribed medication? Yes No

Medication(s) _____________________________________ Purpose ____________________________________

5. Date of last tetanus shot ____ /____ / ____ 6. Does student wear contact lenses? Yes No

Student resides with: Mother/Guardian Only Father/Guardian Only Both Parents

Father's Name _________________________________ Mother's Name _________________________________

Address _______________________________________ Address (if different) __________________________

City___________________ State_____ Zip___________ City___________________ State_____ Zip ___________

Email ____ Email ____

Home Phone ( ) ____________________________ Home Phone ( ) ____________________________

Cell Phone ( ) ____________________________ Cell Phone ( ) ____________________________

Work Phone ( ) ____________________________ Work Phone ( ) ____________________________

Contact if parents cannot be reached _________________________________ Phone ( ) ________________

Family Physician Name ____ Phone ( ) ________________

Insurance Company Name ____ Phone ( ) ________________

Insurance Company Address ____

Policy Number_________________________ Group Number ____________ Hospital Preference ________________

***Parent or legal guardian** ______________________________ ________________________ **Date** ___/___/ ____________

(signature) (printed name)

NOTE: School Nurses do not accompany students on field trips and every effort will be made for medications to be administered. All medications taken must be ordered by a physician and permission granted by parent. Parents/guardians may be asked to accompany students in some circumstances.

DO NOT WRITE BELOW THIS POINT –

This form will be notarized by the **BAND BOOSTER SECRETARY** at a later date if needed for out-of-state travel.

CERTIFICATE OF ACKNOWLEDGMENT

City/County of _________________

Commonwealth of Virginia

The foregoing instrument was acknowledged before me this ______ day of ______________, 20 _____

By ____.

(Name of person seeking acknowledgment)

____

Notary Public