

MASON INSTRUMENTAL MUSIC DEPARTMENT
EMERGENCY MEDICAL AUTHORIZATION

Name _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone-Mother _____

Cell Phone _____ Work Phone-Father _____

Primary Parent Email Address _____

IN CASE OF EMERGENCY, NOTIFY: (If parent/Guardian cannot be reached)

Name _____

Address _____

Phone _____ Relationship to Student _____

HEALTH HISTORY

Have or subject to: (Check if YES)

Asthma Fainting Spells Convulsions Diabetes Heart Trouble Swimming restrictions
 Allergic reaction to any medication or food If yes, Describe _____
 Other If yes, Describe _____

Have difficulty with: (Check if YES)

menstrual problems measles lungs bed wetting digestion eyes/ears/nose/throat
 sleepwalking chicken pox mumps whooping cough diphtheria German measles

Condition now requiring medication _____

Name of Medication _____

Any restriction of activity for medical reasons? _____

Health insurance coverage: Company Name _____ Policy # _____

I hereby give my consent in the event reasonable attempts to contact me or other parent of guardian have been unsuccessful, for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital).

(Date)

(Signature of Parent/Guardian)

OR

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

(Date)

(Signature of Parent/Guardian)