MEDINA MUSICAL BEES
EMERGENCY MEDICAL INFORMATION FORM

STUDENT INFORMATION

Student's Name ____ Birth Date ________________________
(last) (first) (middle)

Student's Address ________________________________ City _________________ Zip ________

Student Cell Phone (for emergency use) __________________________

PARENT/GUARDIAN INFORMATION

Mother's Name/Legal Guardian ____

E-Mail (please make legible)____

Home Phone _________________Work Phone ___________________Cell Phone _____________________

Father's Name/Legal Guardian ____

Home Phone _________________Work Phone ___________________Cell Phone _____________________

E-Mail (please make legible)____

Emergency Contact if unable to contact Parent/Guardian:

Name ____ Relationship _________________________

Best Phone to Reach ________________________________

STUDENT HEALTH INFORMATION

Family Physician _____________________________________ Office Phone ________________________

Office Address _____________________________________ City _________________ Zip _____________

Insurance Company __________________________________ Policy # ______________________________

Insurance Company Phone Number ________________________

Student has a medical history of: *(check if applicable and explain below)*

______ Diabetes ______ Asthma Attacks ______ Cardiac Condition ______ Frequent Fainting
______ Epilepsy ______High Blood Pressure ______ Frequent Nose Bleeding
______ Other (that we should be aware of for this activity)
Explain: ____

____

Student is allergic to: (check if applicable and explain below)

______Penicillin ______Sulfa ______Aspirin ______Tetracycline ______Nut Products

______Insect Stings ______Milk Products ______Egg Products ______Other Explain:____________________

____

Student is presently taking the following prescribed medications: ____________________________________

____

Date of last Tetanus Shot: _____________

Do you give the band staff permission to provide your child with Tylenol, Advil, Benadryl or Dramamine if it is available and requested by your child for medical symptoms? ________ Yes _________ No

If it is available, would you prefer your child to have: ____ Tylenol ____ Advil ____ Benadryl ____ Dramamine

PLEASE COMPLETE BOTH SIDES OF FORM

CONSENT FOR TREATMENT

TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, 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 any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

______________________________ ____

Date Signature of Parent/Guardian

Any other additional facts concerning the child's medical history that were not included on the first page that a physician should be alerted to:

____

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____

REFUSAL TO CONSENT (Do not complete part 2 if you completed part 1)

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 the following action:

____

____

____

______________________________ ____

Date Signature of Parent/Guardian