

# 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

# 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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