Eastlake North High School Music Emergency Medical Information

Marching Band- Wind Symphony - Symphonic Band - Jazz Band

2022-2023 School Year

Please Return to Mr. Sell by May 27th

I. STUDENT INFORMATION

NAME: ____________________________BIRTH DATE: __________ AGE: _____GRADE:____

PHONE (____)___________________________ CELL (_______)_________________________

FULL ADDRESS:____

FAMILY DOCTOR: __________________________ PHONE (_____)___________________

FAMILY DENTIST: __________________________ PHONE (_____) ___________________

MEDICAL SPECIALIST: ______________________ PHONE (_____) ___________________

II. PARENT/LEGAL GUARDIAN

NAME: ____

ADDRESS (IF DIFFERENT) ____

FATHER'S EMPLOYER ____

FATHER'S WORK PHONE (_____)__________________ CELL (____) ________________

MOTHER'S EMPLOYER ____

MOTHER'S WORK PHONE (_____) _________________ CELL (____) ________________

OTHER EMERGENCY CONTACTS (OPTIONAL):

NAME: __________________________________ PHONE (_____) ___________________

NAME: __________________________________ PHONE (_____) ___________________

III. INSURANCE INFORMATION: PLEASE ATTACH COPY OF INSURANCE CARD HERE

(FRONT & BACK), or attach as a separate sheet:

PROVIDER: ____________________________ CERTIFICATE #: ___________________________

GROUP _______________________ POLICY HOLDER'S NAME ___________________________

IV. MEDICAL INFORMATION

ALLERGIES: ____

____

DENTAL PROBLEMS: ____

CHRONIC MEDICAL CONDITIONS (CIRCLE OR LIST):

ASTHMA DIABETES SEIZURES HIGH BLOOD PRESSURE HEART PROBLEMS

OTHER CHRONIC MEDICAL CONDITIONS: ____

____

OTHER CONDITIONS THAT MAY BE AFFECTED BY THE PHYSICAL NATURE OF MARCHING BAND:

____

____

____

CURRENT MEDICATIONS: ____

____

EMERGENCY MEDICATION THAT THE STUDENT CARRIES WITH THEM

____

____

V. MEDICAL CONSENT (*MUST SIGN EITHER TO GRANT OR REFUSE CONSENT*)

Purpose: To authorize the provision of emergency treatment for band/choir members, chaperones, or staff who become ill while traveling with or in the company of the Eastlake North High School Bands and Choirs when relatives cannot be reached.

A. TO GRANT CONSENT

In the event reasonable attempts to contact individuals listed above have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. ________________ (PHYSICIAN) or Dr. _______________ (DENTIST), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer to any reasonably accessible hospital.

The authorization does not cover major surgery unless the medical opinions of the two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

DATE: ____________ PARENT/GUARDIAN SIGNATURE: ________________________________

-OR-

B. REFUSAL TO CONSENT- <u>DO NOT</u> sign here if you have signed part A to grant consent.

I **<u>DO NOT</u>** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical or dental treatment, I wish the school authorities to take no action or to (write your instructions on the the space below):

____

DATE: ____________ PARENT/GUARDIAN SIGNATURE: ________________________________

This form will be destroyed at the conclusion of the school year.