AUTHORIZATION FOR MEDICAL CARE

This page is due *Monday, August 26!*

_____
Student's Name

_____
Parent(s)/Guardian(s) Name(s)

_____ _____
Address City Zip Code

_____ ____/____/____ _____ _____
Age Birth Date Grade Home Telephone

Allergies: _____

_____

Necessary Medications: _____

_____

Medical Conditions (asthma, diabetes, etc,): _____

_____

_____ _____ _____
Father's/Guardian's Employer City Telephone

_____ _____ _____
Mother's/Guardian's Employer City Telephone

_____ _____ _____
Emergency Contact Person Relationship Telephone

_____ _____ _____
Emergency Contact Person Relationship Telephone

_____ _____
Health Insurance Co./Medical Policy Number

COMPLETE BOTH SIDES

Kingsburg High School
INSTRUMENTAL MUSIC PROGRAM

Medical Form (cont'd)

_____	_____	_____
Family Doctor/Clinic	City	Telephone

If an emergency should arise which requires medical attention or hospitalization and we as parents or guardians cannot be contacted, you are authorized to take whatever steps are needed to protect the health of this student.

_____
_____
Parent(s)/Guardian(s) Signature(s)

_____	_____
Date	Date

After filling out the FRONT and BACK of this page, return by *Monday, August 26!*