Ensemble: VS   VV   BR   CR   CC   GC   VC   # MEDICAL CONSENT FORM

Student Name _____ Birthdate: ___/___/___ Age:_____ Sex: M   F

Address _____ City _____ State _____ Zip _____

Parent #1/Legal Guardian's Full Legal Name _____

_____   _____   _____
Parent #1 Home Phone   Parent #1 Cell Phone   Parent #1 Work Phone

Parent #1/Legal Guardian's Full Legal Name _____

_____   _____   _____
Parent #1 Home Phone   Parent #1 Cell Phone   Parent #1 Work Phone

(1) Additional Contact If Parents Are Unavailable _____ Relation _____

_____   _____   _____
Home Phone   Cell Phone   Work Phone

(2) Additional Contact If Parents Are Unavailable _____ Relation _____

_____   _____   _____
Home Phone   Cell Phone   Work Phone

Name of Family Physician _____ Family Physician Phone Number _____

List any diseases, physical or mental limitations, or medical conditions. (Asthma, Diabetes, Etc.)

_____

Allergies To Food, Medication, Insects, Other? (Please Circle)   Yes   No

If yes, please list _____

Presently taking any prescription or non-prescription medications?   (Please Circle)   Yes   No

If yes, what is it and what is the daily dosage _____

If yes, does your student need adult supervision with their medication?   (Please Circle)   Yes   No

Can your student be given the following? *(Please initial those that are allowed to be given.)*

_____Tylenol _____Ibuprofen _____Pepto Bismol/Imodium _____Benadryl _____Dramamine

Date of Last Tetanus Shot _____/_____/_____

Other conditions or limitations we should be aware of? (previous operations, serious injuries, dietary restrictions, etc)

If yes, please explain _____

By signing below, parent(s) authorize *The Huntington North Choral Department* to consent on Parent's behalf to any medical attention deemed necessary for the student. The Parent(s) personally assumes all liability for medical bills, claims for pain and suffering, civil damages, or any other liability resulting directly or indirectly from the medical attention. Parent understands and agrees that this consent is given in advance of any specific diagnosis or treatment. Further, this consent is given to encourage the physician, dentist, or surgeon, and those persons who have temporary custody of the minor, to exercise his/their best judgment as to such diagnosis or medical, dental, or surgical treatment.

Signature of Parent/Legal Guardian _____ Date _____