Authorization to Render Emergency Medical, Dental, Surgical or Hospital Care to a Minor

Dear Parent or Guardian,

It is once again time to update the Emergency Medical Information files for members of the band and color guard at Vista High School. It is to everyone's advantage that you will make a complete and frank statement regarding your child's health. Please include anything that will require special attention as well as a list of medications (including aspirin), or foods, to which he/she may be allergic to and should not be given. **This information will be kept in strict confidence.**

Student Legal Name: _____

Grade: _____ **Date of Birth**: _____

I. The flowing is a list of aliments and /or conditions, which may pertain to your child. If the condition has never existed, leave the space blank. List any additional information that might be helpful.

Appendicitis _____
Asthma _____
Chronic Cough _____
Constipation _____
Diabetes _____
Ear Infection _____
Emotional Distress _____
Epilepsy _____
Fainting _____
Hay Fever _____
Heart Disease _____
Mononucleosis _____
Rheumatic Fever _____
Recent Surgery _____
Tonsillitis _____
Tetanus _____
Last Injection _____
Pneumonia _____
Motion Sickness _____
Other _____

II. Specify allergy to **drugs** (i.e. Penicillin, Insulin, etc.) or **foods**:
_____

_____

III. Is the student currently taking any medications? (Include anti- convulsive, antihistamine, insulin, and tranquilizers) _____

(Medical Information Continued)

IV. Thoroughly discuss here and with the Band Director prior to each event, the medication, the dosage and the condition for which it is prescribed:

_____

V. At no time is my child to take: _____Aspirin, ____ Ibuprofen, or _____ Acetaminophen.

Statement of Authorization

The undersigned parent or legal guardian of _____ a minor, hereby authorizes the Band Director; and/or designated adult, to consent to any emergency medical or dental treatment to be rendered to said minor under the supervision and upon the advice of a physician, surgeon, or dentist licensed under the provisions of the California State Medical/Dental Practice Act. This authorization shall remain effective until July 1, 2020 or sooner if revoked by the undersigned in writing, or by the Band Director or any Administrator of Vista High School, Vista, California.

Parent/Guardian Signature _____ Date _____

Print Name and Relationship _____

Home Telephone _____ Alternate Telephone _____

Address _____ City/Zip _____

Family Physician _____ Telephone _____

Insurance Company _____

Policy Number _____

Other Contact Person(s) _____