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 following is a list of aliments and/or conditions, which may pertain to your child. If applicable, please state the <u>age of occurrence</u>. 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, 2016 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) ____

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