

# NORTH HALL HIGH SCHOOL BAND



**4885 MT. VERNON ROAD, GAINESVILLE, GA 30506**

## **CONSENT FOR MEDICAL TREATMENT**

In effect 7/1/2010 – 7/1/2011

STUDENT'S FULL LEGAL NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

GRADE \_\_\_\_\_

PARENT(S)/GUARDIAN(S) \_\_\_\_\_

PHONE # H: \_\_\_\_\_ W #1: \_\_\_\_\_ W #2: \_\_\_\_\_

MOBILE #1: \_\_\_\_\_ MOBILE #2: \_\_\_\_\_

PLEASE LIST 2 EMERGENCY CONTACTS (Other than parents)

NAME	RELATIONSHIP	HOME PHONE#	MOBILE PHONE #
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1)	_____	_____	_____
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2)	_____	_____	_____
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### **MEDICAL INFORMATION**

All information is confidential and will be seen only by the Band Director and chaperones who are responsible for medical care.

ALLERGIES (Medical and Environmental) \_\_\_\_\_

CURRENT MEDICAL CONDITIONS \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

IMPORTANT MEDICAL HISTORY INFORMATION \_\_\_\_\_

DATE OF LAST TETANUS \_\_\_\_\_

CIRCLE WHICH OVER-THE-COUNTER MEDICATIONS ARE ACCEPTABLE TO ADMINISTER  
TO YOUR STUDENT      **TYLENOL**  
   **MOTRIN**  
   **ADVIL**  
   **BENADRYL**  
   **PEPTO BISMAL**  
   **HYDROCORTISONE CREAM**

**INSURANCE INFORMATION (Please attach a copy of the front and back of your insurance card)**

CARRIER \_\_\_\_\_ POLICY # \_\_\_\_\_  
GP PLAN # \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ PH # \_\_\_\_\_  
INS CARRIER PH # \_\_\_\_\_

IF NO INSURANCE, PLEASE COMPLETE THE FOLLOWING:

For and in consideration of emergency services and goods rendered by or through the attending physician(s) the undersigned guarantees payment in full, immediately upon receipt of final billing.

SIGNATURE OF PARENT/ LEGAL GUARDIAN\* \_\_\_\_\_

PRINT NAME \_\_\_\_\_

**RELEASE (ALL MUST BE COMPLETE)**

I, the undersigned, being the parent or legal guardian of

STUDENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Hereby grant authorization to the Band Director, chaperones of North Hall High School Band Association, standing in loco parentis, to obtain emergency medical and/or surgical treatment and procedures from a physician or hospital emergency room on behalf of the above named minor. I also give permission to administer over the counter medication as listed above if necessary.

SIGNATURE\* \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NOTARY: \_\_\_\_\_

\* Sign in the presence of a notary