Independence High School Band - Frisco, TX

AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT OF MINOR STUDENT

Student Name:_____ Birthdate:_____
Date:_____ School:_____ Grade:_____
Address:_____ Home Ph.:_____
City: _____ Zip Code:_____

TO PARENT OR GUARDIAN: To serve your child in case of ACCIDENT or SUDDEN ILLNESS, please provide the following information:

Mother/Guardian: _____ Bus. Phone:_____
Father/Guardian: _____ Bus. Phone: _____

List two people who will assume temporary care of your child if you cannot be reached:

Name: _____ Name:_____
Address: _____ Address: _____
Phone: _____ Phone: _____
Relation: _____ Relation: _____

List any health conditions such as heart problems, diabetes, epilepsy, eye or ear problems, or any chronic condition:

_____
_____

List any allergies: _____

List any medications taken regularly:

_____
_____

Doctor: 1st Choice: _____ Phone: _____
2nd Choice: _____ Phone: _____

Dentist: _____ Phone: _____
Hospital: Choice: _____ Phone: _____

Medical Insurance Provider: _____
Policy No.: _____

Please initial ONE of these statements:

_____ I authorize immediate medical treatment for the above-named student.
_____ Contact this student's parent/guardian before seeking medical treatment.

_____ _____
Parent/Guardian Signature *Date*