

**Hamilton High School West Bands
Band Trip Medical Treatment Authorization Form**

Please Type or Print. This form is required for all Band Members enrolled in the Hamilton High School West Bands, and MUST be completed by a parent or guardian.

NAME _____ HEIGHT _____ WEIGHT _____ SEX _____

ADDRESS _____ APT _____ ZIP CODE _____

PHONE NUMBER _____

Person to be contacted in case of an emergency _____

Relationship to student _____

Home Phone _____ Work Phone _____

Cell Phone(s) _____

Name of Doctor _____ Phone Number _____

Doctor's Address _____ ZIP _____

Name of Health Insurance Co _____

Policy Number _____ I.D. Number _____

PLEASE ANSWER YES OR NO:

1. Will your son or daughter be taking drugs or medication of any type? _____

*** What over the counter medication(s) do you give permission for the trip nurse to administer to your child? _____

2. Has s/he ever been treated for: (if currently being treated, please indicate)

- | | |
|-----------------------------------|--|
| A. Nervousness? _____ | H. High Blood Pressure? _____ |
| B. Any Mental Disorder? _____ | I. Severe or Frequent Headaches? _____ |
| C. Convulsions or Epilepsy? _____ | J. Asthma? _____ |
| D. Fainting Spells? _____ | K. Ulcers? _____ |
| E. Heart Condition? _____ | L. Diabetes? _____ |
| F. Rheumatic Fever? _____ | M. Allergic Reaction to Medication? _____ |
| G. Cancer or Tumor? _____ | N. Any Other Allergies or Illnesses? _____ |

3. Does s/he have any other physical limitations? _____

Give details of "yes" questions to any of the questions above. Give dates of treatment, names, addresses of attending physicians, hospitals and clinics. (Use reverse if necessary)

PLEASE READ CAREFULLY: I hereby certify that the information given above is correct. In case of medical emergency, I understand that every effort will be made to contact the person designated above. In the event that the person cannot be reached, or time does not permit, I hereby give permission to a licensed physician to provide proper treatment for, including hospitalization, immunization or injection, anesthesia, or surgery for my son/daughter.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____