

# MEDICAL TREATMENT FORM

Portsmouth High School Band  
120 Education Ln, Portsmouth, RI 02871  
1-401-683-2124

Student \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

*I, the undersigned, being the parent or legal guardian of the student named above, hereby authorize any necessary medical treatment while participating in any band event. I understand the parent will be contacted immediately if a medical emergency occurs. I guarantee payment of all charges incurred during this medical treatment (physician, hospital, X-ray, lab, medications, ambulance, etc.). I also give my permission for the staff or chaperones accompanying the band to give first aid and administer over-the-counter medicines if needed.*

1. Allergies to food, medication, etc. (If none, so state) \_\_\_\_\_

2. Allergies to insect bites and stings. Please describe student's reaction and medicine taken (If none, so state) \_\_\_\_\_

3. Special medical problems (If none, so state) \_\_\_\_\_

4. Medication taken regularly (If none, so state)

Medicine \_\_\_\_\_ Purpose \_\_\_\_\_

Medicine \_\_\_\_\_ Purpose \_\_\_\_\_

5. Date of last tetanus shot \_\_\_\_\_

6. Family physician \_\_\_\_\_ Phone (Physician) \_\_\_\_\_

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Name of Parents / Guardian \_\_\_\_\_

Parent's / Guardian address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent / Guardian CELL# \_\_\_\_\_ 2<sup>nd</sup> Cell (optional) \_\_\_\_\_

Father's place of employment: \_\_\_\_\_ Phone \_\_\_\_\_

Mother's place of employment: \_\_\_\_\_ Phone \_\_\_\_\_

Contact Person if parents cannot be reached \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Any Additional Concerns: \_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_