MEDICAL TREATMENT FORM

PORTSMOUTH HIGH SCHOOL MUSIC DEPARTMENT

120 Education Ln, Portsmouth, RI 02871

1-401-683-2124

_____ _____ M F

Student Name Date of Birth Sex

_____ _____

Parent's / Guardian's Name Parent's / Guardian's Name

__(____)_____ __(____)_____ __(____)_____ __(____)_____

Home Phone Work Phone Home Phone Work Phone

__(____)_____ __(____)_____

Cell Phone Cell Phone

_____ _____

Address Address

_____ _____

City, State, Zip City, State, Zip

Alternative Emergency Contacts

_____ _____

Primary Emergency Contact Secondary Emergency Contact

__(____)_____ __(____)_____ __(____)_____ __(____)_____

Home Phone Work Phone Home Phone Work Phone

__(____)_____ __(____)_____

Cell Phone Cell Phone

_____ _____

Address Address

_____ _____

City, State, Zip City, State, Zip

Medical Information

_____ _____

Physician's Name Phone Number

_____ _____

Insurance Company Policy Number

_____

_____

_____

Allergies / Special Health Concerns / Medications

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.

_____ _____

Parent's Guardian's Signature Date