MEDICAL TREATMENT FORM

PORTSMOUTH HIGH SCHOOL MUSIC DEPARTMENT
120 Education Ln, Portsmouth, RI 02871
1-401-683-2124

Date:_____

_____ _____ 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