

North Scott High School Bands  
MEDICAL RECORD and AUTHORIZATION FOR MEDICAL TREATMENT

This form is available for download at: [www.nsband.com/communications.htm](http://www.nsband.com/communications.htm)  
If possible, please fill out this form on your computer before printing and signing the form.

\_\_\_\_\_  
Student Last Name                      First Name                      Middle                      Date of Birth

Parent Name(s) \_\_\_\_\_  
Parent Cell \_\_\_\_\_

\_\_\_\_\_  
Home Address                      City, State, ZIP                      Home Phone                      Student Cell

If neither parent can be reached at the above phone numbers, please give:

Father's Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Mother's Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

In the event of an emergency and neither parent can be reached, who should be contacted?

\_\_\_\_\_  
Student's Physician \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_

Is this student subject to any of the following:

\_\_\_\_\_ Asthma    \_\_\_\_\_ Fainting Spells    \_\_\_\_\_ Heart Trouble    \_\_\_\_\_ Diabetes  
\_\_\_\_\_ Hyperventilation    \_\_\_\_\_ Convulsions    \_\_\_\_\_ Physical restrictions  
\_\_\_\_\_ Other \_\_\_\_\_

Give any pertinent information regarding the student's condition, restrictions, activities, etc.

\_\_\_\_\_  
Has this student any physical disability or limitations not specified above, which we should know about?  
Specify \_\_\_\_\_

Does he/she have any allergies?    Food \_\_\_\_\_    Pollen Insect Bite \_\_\_\_\_    Medication \_\_\_\_\_  
Specify medication allergies \_\_\_\_\_  
Other (Please describe) \_\_\_\_\_

Is he/she presently under a doctor's care? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, for what? \_\_\_\_\_

Does he/she take regular medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, specify and include dosage instructions \_\_\_\_\_

Medical insurance that would cover student during the trip in the event of sickness or accident:

Insurance Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy Number \_\_\_\_\_ Policyholder \_\_\_\_\_

PLEASE READ THE FOLLOWING AND SIGN:

I (We), \_\_\_\_\_ parent/legal guardian of \_\_\_\_\_, consent to medical and/or emergency treatment as the physician deems necessary to be rendered when the need for such treatment is immediate. I also authorize the use of our family medical insurance company.

\_\_\_\_\_  
Parent or guardian                      Parent or guardian                      Date