PHILIP BARBOUR HIGH SCHOOL BAND
EMERGENCY MEDICAL TREATMENT FORM

Student Name _____
First Middle Last

Birth Date _____ Social Security Number (optional)_____

Height _____ Weight _____ Tetanus Shot: **Yes No** **If yes, when** _____

Parent/Guardian Name _____

Address _____

Phone: HOME _____ WORK _____ CELL _____

Person other than parent to contact in an **EMERGENCY:**

Name _____ Relationship to Child _____

Phone: HOME _____ WORK _____ CELL _____

Family Physician _____ Phone Number _____

ALLERGIES, HEALTH PROBLEMS, HANDICAPS OR SPECIAL PROBLEMS (be very specific):

_____

_____

Current Medications _____

Insurance Co. _____ Policy No. _____

Policyholder's Name _____

Policyholder's Social Security Number (optional) and Place of Employment: Policyholder's Date of Birth:

_____

I grant the school and its designated representatives the permission to allow for medical treatment in the event of an accident or medical illness. I understand that every effort will be made to notify me before any treatment is undertaken. If I cannot be contacted, I give permission for my child to be moved to a hospital or clinic by car or ambulance, if needed, and for emergency treatment to begin by a physician.

I give permission for his/her band director and/or supervising chaperone to administer the following medications:

_____ **Tylenol** _____ **Motrin (ibuprofen)** _____ **Pepto-Bismol** _____ **Rolaids/Tums** _____ **Benadryl** _____ **Midol**

_____ **Immodium** _____ **Cough Drops/ Medicine** _____ **OTC nasal decongestant** _____ **Aleve** _____ **Dramamine**

_____ **Other (specify):** _____

Parent/Guardian Signature _____ **Date** _____

A COPY OF YOUR INSURANCE CARD IS TO BE PROVIDED

Very important in case of an emergency, the hospital/clinic cannot provide services without this card