

Information Packet - Form A

Amherst Marching Program - Medical/First Aid Form

Student's Name: _____ Child's Birth Date: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Cell Phone: _____

Mother's Name: _____ Father's Name: _____

Other contacts in case you can't be reached Last Tetanus Shot: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please fill out the following Insurance information

Place of Employment: _____ Father: _____ Phone: _____

Mother: _____ Phone: _____

Health Insurance Co: _____ Phone: _____

Insurance ID, Group or Account: _____

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Hospital Preference: _____

Allergic to any Medications or Bandaging Material:

YES NO - If YES, please list them and WHY.

Currently taking medication:

YES NO - If YES, please list them and WHY.

Carries medication:

YES NO - If YES, please list them and WHY.

Please dispense the following medication if needed:

Advil: **Y or N**

Tylenol: **Y or N**

Pepto Bismol: **Y or N**

Benadryl: **Y or N**

Use this space to any list items on the left. If needed, attach a separate sheet of paper to this medical form to explain why.

PLEASE READ & SIGN THE BACK OF THIS FORM!

EMERGENCY MEDICAL AUTHORIZATION

SIGNING: By signing this form, you are stating that the information listed on the preceding page is, to your knowledge, correct information. Your signature in Part I will give us permission to have your child receive emergency care and/or treatment at a health care facility if deemed necessary. Part II is a refusal to grant consent.

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I or PART II MUST BE COMPLETED

PART I (To Grant Consent)

I hereby give consent to the medical care providers and local hospital listed on the previous page to be called in the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by said doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the student's medical history including allergies, medications being taken, and any physical impairments which a physician should be alerted is listed on the previous page.

Date: _____ Signature of Parent/Guardian: _____

PART II (Refusal To Grant Consent)

I **DO NOT** give consent for emergency medical treatment of my student. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Course of Action **MUST BE STATED:**

Date: _____ Signature of Parent/Guardian: _____

(only sign if you do not give consent to treatment)