

**Mount Carmel Area
High School Band
MEDICAL FORM**

MEDICAL AUTHORIZATION

Student name: _____

Date: _____

This authorizes a licensed physician, surgeon, or other recognized hospital staff member or emergency personnel to carry out emergency medical care deemed necessary for this student, _____, in an emergency when normal permission is unavailable.

Parent/Guardian Signature

Parent/Guardian Printed

PARENT EMAIL: _____

Student Name: _____

Address: _____

City & Zip: _____

Telephone: _____ Birthdate: _____ Blood type (if known): _____

Allergies (drugs, insect bites, etc.): _____

Current Medications and Dosages: _____

Can your child take the following headache and stomach medications?

Tylenol (Acetaminophen): Yes No

Advil (Ibuprofen): Yes No

Pepto-Bismol: Yes No

Kaopectate: Yes No

Immodium AD, etc: Yes No

Motion-sickness medicines (ie: Dramamine, etc.): Yes No

**Mount Carmel Area
High School Band
MEDICAL FORM**

Medications that **cannot** be taken: _____

Medical history (diabetes, epilepsy, heart disease, asthma, contact lenses, etc.):

Name of Insurance Company: _____

Group/Contract number: _____

Other concerns/comments: _____

In case of an emergency, please notify at least one of the following

Include name, address, relationship to child, and their home & work phone numbers

1. _____

2. _____

3. _____

I give my permission for any and all chaperones that will be responsible for

_____, at any given time, to view this form.

Parent/Guardian Signature

Parent/Guardian Printed

Revised June 2015