2021 – 2022 WHS Vocal Music Emergency Medical Form

Please circle ALL choirs the student is participating in for the 2021/22 school year

Men's Chorus Women's Chorus Concert Choir Symphonic Chorale

STUDENT'S NAME_____ **GRADE**_____
ADDRESS_____
CITY_____ **STATE**_____ **ZIP**_____
BIRTHDATE_____ **HOME PHONE**_____ **STUDENT CELL**_____

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:_____

_____

_____

CHILD LIVES WITH (circle all that apply): Father, Mother, Step-Parent, Foster Parent, Guardian
FATHER'S/GUARDIAN'S NAME_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
HOME PHONE_____ CELLPHONE_____ WORK PHONE_____
EMPLOYER_____ EMAIL_____
MOTHER'S/GUARDIAN'S NAME_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
HOME PHONE_____ CELLPHONE_____ WORK PHONE_____
EMPLOYER_____ EMAIL_____

In the event this student becomes ill at school but does not need medical attention, name people to be contacted if you cannot be reached.

1) Neighbor/Relative_____ Phone (H)_____ (W)_____
2) Neighbor/Relative_____ Phone (H)_____ (W)_____
3) Neighbor/Relative_____ Phone (H)_____ (W)_____

PART 1 – TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone) or _____ (other parent) at _____(phone) have been unsuccessful, I hereby give my consent for the (1) administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or 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 before the surgery is performed.

Date _____ **Signature of Parent/Legal Guardian** _____
Address_____

PART II – REFUSAL TO CONSENT

DO NOT complete if you completed part I

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

_____

_____

Date _____ **Signature of Parent/Legal Guardian** _____
Address_____