Emergency Contact / Treatment Authorization Form[1]

Student First Name:	
Student Last Name:	
HS Graduation Year:	
Primary Instrument (write CG if colorguard)	
Street Address:	
City & Zip Code	
Parent/Guardian Home Phone	
Parent/Guardian 1 First and Last Name	
Parent/Guardian 1 email	
Parent/Guardian 1 Cell Phone	
Parent/Guardian 1 Work Phone	
Parent/Guardian 2 First and Last Name	
Parent/Guardian 2 email	
Parent/Guardian 2 Cell Phone	
Parent/Guardian 2 Work Phone	
Are parents/guardians at two separate addresses	YES NO
Other Emergency Contact (if parent unavailable): Full name and Phone Number	
Medication(s) student uses:	

2019-2020

Purpose of Medication:	
List ANY condition that supervising adults should keep their eyes open for. This might include physical conditions, prior injuries, or any other conditions.	
Circle any applicable Health Conditions: Heart trouble, palpitations, current skin conditions, kidney problem, asthma, fatigue, dizziness or fainting, history of family member with heart attack under 50 years of age or sudden death, diabetes, high blood pressure, seizures, chest pain, eye glasses or hearing aid	
Indicate FULL or RESTRICTED participation	FULL RESTRICTED
Physician's Name	
Physician's Phone Number	
Insurance Company Name	
Policy/Group #	
Date	

I hereby state that the above information is true and correct and give my consent for the above-named student to participate in all band programs and go with a representative of the school on any trips. In case of injury, the school representative is authorized to have him/her treated.

Parent/guardian signature: