TEACH TECH THEATRE

EMERGENCY MEDICAL FORM

Authorization to render Medical, Dental, Surgical or Hospital Care to a Minor

Dear Parents or Guardians:

Please complete. Include anything which will require special attention as well as a list of drugs (including aspirin) to which he or she may be allergic or should not be given.

The following is a list of diseases and/or conditions which may pertain to your student. State the age at which it occurred. If condition has never existed, write "None". List any additional information which might be helpful.

Appendicitis _____ Hay Fever _____ Asthma _____ Heart Disease _____ Chronic Cough _____ Mononucleosis _____ Constipation _____ Rheumatic Fever _____ Diabetes _____ Tonsillitis _____ Ear Infection _____ Pneumonia _____ Epilepsy _____ Motion Sickness _____ Fainting _____ Hypoglycemia _____

Other (describe thoroughly)

Is the student taking any medication regularly or periodically? Yes_____ No_____

If "Yes", what? _____ How often? _____

Be sure to thoroughly discuss the medication, the dosage, and the condition for which is prescribed with the chaperone/chairpersons.

STATEMENT OF AUTHORIZATION

The UNDERSIGNED parent or legal guardian of _____, a minor, hereby authorizes (teacher) _____and/or an authorized chaperone, to consent to any and all medical treatment to be rendered to said minor under the supervision and upon advice of a physician, surgeon, or dentist licensed under the provision of a State Medical Dental Practice Act. This authorization shall remain effective until the end of the school year.

Parent(s)/Guardian(s) Name (print)_____

Address_____ City_____ Zip_____

Home Telephone_____ Alternate Phone_____

Student's Birth Date _____

PRESENT INSURANCE COMPANY_____

Family Doctor's Name_____ Telephone_____

Family Dentist Name _____ Telephone_____

Parent(s)/Guardian(s) Signature_____ Dated_____

Witnessed By_____