

Dalton High School

Dalton, Georgia

Permission for Medical Treatment

(Required)

To Whom It May Concern: I, the undersigned, being the parent, legal guardian, or legal next-of-kin of:

_____ (Full Name of Student)

hereby authorize any necessary medical treatment for this person while participating in band activities. I also guarantee payment of all charges incurred during the treatment (Ambulance, physician, hospital, x-ray, lab, drugs, etc.).

1. ALLERGIES TO FOODS, MEDICATIONS, ETC. (If none, so state; if yes, specify).

2. Special medical problems (If none, so state, if yes, specify).

3. Is the student now under medical care? _____

If yes, describe nature of illness and treatment: _____

4. Does participant carry medication on person? _____ (If none, so state, if yes, specify).

Name of medication(s) _____

Purpose _____

5. Date of last tetanus: _____

6. Family physician/clinic: _____

Phone: _____ Office address: _____

7. Home Address: _____

8. Home phone: _____ Business Phone/Mother _____

Business Phone/Father _____

SIGNATURE OF PARENT / LEGAL GUARDIAN

DATE

Print name of person signing: _____ Relationship of person signing: _____

Emergency name and numbers if above not available: _____

Insurance Company: _____ Policy Number: _____

-- Please provide a copy of your insurance card front/back. --

Notary Acknowledgement

Seal:

State of _____

County of _____

Witness my hand this _____ day of _____, 20____.

Notary Signature: _____