

PERMISSION FOR MEDICAL TREATMENT

All-State (check one) Band Orchestra Children's Chorus Jr High Treble Chorus
 Jazz Band Chorus Jr High Mixed Chorus

Last name _____ First name _____ M.I. _____

TO WHOM IT MAY CONCERN: I (we), the undersigned, being the parent, legal next-of-kin, or legal guardian of the above named person, hereby give my authorization for any necessary medical treatment for this person while participating in the Kentucky Music Educators Association All-State Bands, Orchestras or Chorus. I also guarantee payment of all charges incurred during this person's treatment (physician, hospital, X-ray, lab, drugs, ambulance, examination, etc.), minor surgery (hospital care, physicians, drugs, X-rays, lab, etc.), and/or hospital care as deemed necessary by a physician. I understand this consent is valid from February 8, 2012 to February 11, 2012.

I hereby entrust the care of above named person to the duly authorized representative of the Kentucky Music Educators Association or their school band, choral or orchestra director (adult).

Note: Give following information for doctor to treat above person. Please be as accurate as possible and list everything.

In regard to such person, I submit the following information: (Please type or print)

1 Allergies to foods, medications, etc. (If none, so state.) Additional space on back.

2 Special medical problems. ((f none, so state.) Additional space on back.

3 Does participant carry medications on person? (If none so state.) Additional space on back.

Medication _____ Purpose _____

4 Date of last Tetanus shot _____

5 Family physician: _____

Address _____ City _____ Zip _____

Telephone _____

6 Medical insurance company _____ Policy number _____

Person carrying insurance: _____

PARENTS OR LEGAL REPRESENTATIVE'S SIGNATURE

Please type or print

Parent/guardian signature

Witness signature - Non-family member

Typed or printed parent/guardian name

Date signed

Address _____

City _____ Zip _____

Father's (male guardian) telephone Day _____ Night _____

Mother's (female guardian) telephone Day _____ Night _____

Emergency telephone number _____ Relationship _____

High school Western Hills High School Director Tiffany Marsh

School address 100 Doctors Drive City Frankfort Zip 40601

School telephone 502-875-8400 Email tiffany.marsh@franklin.kyschools.us