

**ADVANCED CONSENT FOR MEDICAL TREATMENT**

*PRBBA, P.O. Box 819, Suwanee, GA 30024*

THE INFORMATION REQUESTED ON THIS FORM MUST BE SUBMITTED AS PART OF THE REQUIREMENTS FOR PARTICIPATING IN THE PEACHTREE RIDGE HIGH SCHOOL BAND. THE INFORMATION WILL BE TREATED IN A CONFIDENTIAL MANNER AND UTILIZED ONLY IN MATTERS CONCERNING THE HEALTH AND WELFARE OF THE STUDENT. **THIS FORM MUST BE NOTARIZED ONCE COMPLETED.**

**STUDENT'S NAME** \_\_\_\_\_ AGE \_\_\_\_\_ Birthdate \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

**MOTHERS' NAME** \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE(H) \_\_\_\_\_ PHONE(W) \_\_\_\_\_ PHONE(C) \_\_\_\_\_

**FATHERS' NAME** \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE(H) \_\_\_\_\_ PHONE(W) \_\_\_\_\_ PHONE(C) \_\_\_\_\_

**EMERGENCY CONTACT NAME** \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE(H) \_\_\_\_\_ PHONE(W) \_\_\_\_\_ PHONE(C) \_\_\_\_\_

**MEDICAL INFORMATION**

**PRIMARY CARE PHYSICIAN** \_\_\_\_\_ PHONE \_\_\_\_\_

LIST ANY HEALTH PROBLEMS/CONCERNS/LIMITATIONS (Current or Past) THAT WE NEED TO BE AWARE OF:

\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES: \_\_\_\_\_ FOOD: \_\_\_\_\_ DRUGS: \_\_\_\_\_

DATE OF LAST TETANUS INJECTION \_\_\_\_\_

**PRESENT MEDICATION(S) AND DOSAGES**

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ REASON TAKEN \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ REASON TAKEN \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ REASON TAKEN \_\_\_\_\_

MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ REASON TAKEN \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

NAME OF POLICY HOLDER \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**A LEGIBLE COPY OF THE INSURANCE CARD (FRONT AND BACK) IS NECESSARY TO COMPLETE THE STUDENT'S FILE.**

**AUTHORIZATION FOR EMERGENCIES**

1. PERMISSION IS GRANTED TO THE BAND INSTRUCTORS AND CHAPERONES TO ADMINISTER FIRST AID, TO OBTAIN THE SERVICES OF A LICENSED PHYSICIAN AND TO ARRANGE TRANSPORTATION TO A MEDICAL FACILITY IN CASE THE PERSON NAMED IS SERIOUSLY ILL OR INJURED AND REQUIRES HOSPITALIZATION.
2. PERMISSION IS ALSO GRANTED TO THE ATTENDING PHYSICIAN TO RENDER WHATEVER TREATMENT HE/SHE DEEMS FOR THE PERSON'S WELFARE. THE RESPONSIBILITY FOR ALL EXPENSES INCURRED WILL BE ASSUMED BY THE PERSON WHOSE SIGNATURE APPEARS BELOW.
3. I HEREBY RELEASE AND DISCHARGE THE BAND INSTRUCTORS AND VOLUNTEER CHAPERONES FROM ANY AND ALL LIABILITY IN CASE OF ACCIDENT OR ANY OTHER INJURY WHICH MIGHT OCCUR TO MY CHILD THROUGH ADMINISTERING FIRST AID AND TRANSPORTING TO A MEDICAL FACILITY. I HEREBY RELEASE SAID AFOREMENTIONED OFFICIALS FROM ANY LIABILITY FROM ANY INJURY OR DAMAGE, WHICH MIGHT OCCUR.
4. MY CHILD, \_\_\_\_\_, HAS PERMISSION TO TAKE OVER-THE-COUNTER MEDICATIONS FOR MINOR AILMENTS, ACHES AND PAINS, AS DEEMED NECESSARY BY THE BAND INSTRUCTORS AND / OR CHAPERONES, WITH THE EXCEPTION OF THE FOLLOWING SPECIFIC PRODUCTS: \_\_\_\_\_
5. IT IS MY RESPONSIBILITY TO UPDATE THIS AND OTHER MEDICAL INFORMATION WITH THE PEACHTREE RIDGE BAND BOOSTERS ASSOCIATION. TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NOTARY SIGNATURE

\_\_\_\_\_  
DATE

