

## AUTHORIZATION TO RENDER EMERGENCY MEDICAL, DENTAL, SURGICAL OR HOSPITAL CARE TO A MINOR (2021 – 2022)

Dear Parent or Guardian,

It is once again time to update the Emergency Medical Information files for members of the Band (including Color Guard) at Murrieta Valley High School. It is to everyone's advantage that you will make a complete and frank statement regarding your child's health. Please include anything that will require special attention as well as a list of medications (including aspirin) or foods to which he/she may be allergic and should not be given. **This information will be kept in strict confidence.**

**Student Legal Name:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

I. The following is a list of ailments and/ or conditions, which may pertain to your child. If applicable, please state the age of occurrence. If the condition has never existed, leave the space blank. List any additional information that might be helpful.

Appendicitis \_\_\_\_\_

Asthma \_\_\_\_\_

Chronic Cough \_\_\_\_\_

Constipation \_\_\_\_\_

Diabetes \_\_\_\_\_

Ear Infection \_\_\_\_\_

Emotional Distress \_\_\_\_\_

Epilepsy \_\_\_\_\_

Fainting \_\_\_\_\_

Hay Fever \_\_\_\_\_

Heart Disease \_\_\_\_\_

Mononucleosis \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Recent Surgery \_\_\_\_\_

Tonsillitis \_\_\_\_\_

Tetanus \_\_\_\_\_

Last Injection \_\_\_\_\_

Pneumonia \_\_\_\_\_

Motion Sickness \_\_\_\_\_

Other \_\_\_\_\_

II Specify allergy to **drugs** (i.e. Penicillin, Insulin, etc.) or **foods**:

III. Is the student currently taking any medications? (Including anti- convulsive, antihistamine, insulin, and tranquilizers)

**(Complete other side)**

**Medical Information Continued:**

IV. Thoroughly discuss here and with the Band Director prior to each event the medication, the dosage, and the condition for which it is prescribed:

V. At no time is my child to take: \_\_\_\_\_ Aspirin, \_\_\_\_\_ Ibuprofen \_\_\_\_\_, or \_\_\_\_\_ Acetaminophen.

**Statement of Authorization**

The undersigned parent or legal guardian of \_\_\_\_\_, a minor, hereby authorizes the Band Director, and/or designated adult, to consent to any **emergency** medical or dental treatment to be rendered to said minor under the supervision and upon the advice of a physician, surgeon, or dentist licensed under the provisions of the California State Medical/Dental Practice Act. This authorization shall remain effective until July 1, 2022 or sooner if revoked by the undersigned in writing, or by the Band Director or any Administrator of Murrieta Valley High School, Murrieta, California.

Parent/ Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name and Relationship \_\_\_\_\_

Home Telephone \_\_\_\_\_ Alternate Telephone \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Family Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Other Contact Person(s) and Phone Number(s) \_\_\_\_\_

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