

**Joliet Township High Schools - Instrumental Music Department**  
*Student Medical and Treatment Authorization Form*

**Student Information (Please print)**

Student Name \_\_\_\_\_ Instrument \_\_\_\_\_ Grade: 9 10 11 12

Birthdate \_\_\_\_\_ Male Female

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Numbers: Home (\_\_\_\_) \_\_\_\_\_ Student cell (\_\_\_\_) \_\_\_\_\_

Email addresses: Parents \_\_\_\_\_

Student \_\_\_\_\_

*These will be used for notification of special dates and events.*

**Emergency Contact and Parent/Guardian Information:**

**1<sup>st</sup> Contact:** \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ email \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

**2<sup>nd</sup> Contact:** \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ email \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

3<sup>rd</sup> Contact \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

4<sup>th</sup> Contact \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

**Treatment Authorization**  
**To be completed by Parent or Guardian**

In the event I cannot be reached in an emergency, I hereby authorize Mr. Kevin Carroll, Director of Bands for Joliet West High School, or his adult designee, to seek and obtain medical treatment for my child. I further authorize the selected medical entity to provide emergency medical care for my child; and further, I state that my child is in good health and that I assume the health responsibility for said child.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_ Relationship \_\_\_\_\_  
(parent/guardian)

I hereby give permission to administer over-the-counter medications such as Tylenol, Advil, Antacids, or cold medications only when needed.

List specific over-the-counter medications **NOT** to be given: (Aspirin will **NOT** be administered)

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_ (parent/guardian)

*If you are sending medication with your child, make sure that it is clearly labeled with his/her name, dosage, name of medication and the times to be given. **All prescription medications are to be given to the student's chaperone.***

**Medical Information for** \_\_\_\_\_

**Health Care Providers:**

Family Doctor \_\_\_\_\_ Office phone (\_\_\_\_) \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_

Policy/ID No. \_\_\_\_\_ Plan No. \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Health Insurance Phone No. (\_\_\_\_) \_\_\_\_\_

Do any pre-certification, notification or other requirements exist with respect to the health insurance of the student? If so, please specify \_\_\_\_\_

**Current Medications** \_\_\_\_\_

**General: Does the student have: (if yes, explain)**

Yes  No Allergies? (i.e. food, drug) \_\_\_\_\_

Yes  No Asthma? \_\_\_\_\_

Yes  No Heart Condition? \_\_\_\_\_

Yes  No Vision or Hearing Impairment? \_\_\_\_\_

Yes  No Other? \_\_\_\_\_

**Is student subject to: (if yes, explain)**

Yes  No Headaches? (especially migraines) \_\_\_\_\_

Yes  No Sleep walking? \_\_\_\_\_

Yes  No Upset stomach? \_\_\_\_\_

Yes  No Other? \_\_\_\_\_

**Does student have a reaction to: (if yes, explain)**

Yes  No Bee stings? \_\_\_\_\_

Yes  No Penicillin? \_\_\_\_\_

Yes  No Other? Please specify: \_\_\_\_\_

Yes  No Has the student had any serious illness or surgery **within the past ten years** \_\_\_\_\_

Yes  No Are any drugs ineffective in treatment? \_\_\_\_\_

Yes  No Does the student wear **contact lenses**? \_\_\_\_\_ Date of **last tetanus shot**: \_\_\_\_\_

Yes  No Special Needs or Dietary Restrictions? \_\_\_\_\_

I hereby give \_\_\_\_\_ permission to participate in all activities of the Joliet West Band program as approved by the Joliet Township School Board during the 2009-2010 school year. I also authorize the use of images and audio from band performances and activities to be used in media publications including band related websites.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_ (parent/guardian)

**INFORMATION PROVIDED ON THIS FORM WILL BE USED SOLELY TO PROVIDE APPROPRIATE CARE FOR YOUR CHILD DURING BAND ACTIVITIES AND WILL BE KEPT CONFIDENTIAL.**