Medical History/Consent to Treat

Student Name _____ Phone (_____)_____

Address _____ Birth Date _____

Father/Guardian _____ Phone (_____)_____

Mother/Guardian _____ Phone (_____)_____

Emergency Contact _____ Relationship _____

Address _____

Medical Insurance _____ Policy#_____

Physician _____ Phone (_____)_____

Dentist _____Phone (_____)_____

Daily Medications_____

Medication Allergies_____

Food Allergies_____

Allergic to Bee or Wasp Sting___No___Yes ***If yes, a sting kit and required medication must be sent with child!!!***

Additional Information to help us care for your child:

TO WHOM IT MAY CONCERN: I hereby authorize those persons entrusted with the care of my child, _____, to follow advice of the best available medical personnel to administer any treatments, inoculations, medications and procedures deemed necessary to my child's health and safety.

Signed,

_____ Parent/Guardian

THIS FORM MUST BE TURNED IN NO LATER THAN JULY 17TH, THE FIRST DAY OF BAND CAMP.