Central High School Band

5728 Highway 58 Harrison, TN 37341 (423) 344-1469
Mr. Angelo Kortyka, Director

Medical Treatment Form 2010-2011

Child's Name___________________________________ Male or Female (Circle one)

Date of Birth: _____/_____/_______

Mailing Address____

Home Phone____________________ Alternate Phone(s)_________________________

Parents/Guardians____

Parent(s) Work Phone(s)____

Emergency Contact (*other* than parent/guardian)__________________________________

Emergency Phone______________________________ Relation to Child_____________

Medical History

Operations____

Mental/Emotional Concerns____

Serious Medical Conditions____

Contact Lenses/ Hearing Aides/ Prosthetic Devices________________________________

Date of Last Tetanus Injection______________________ Diabetes: Y/N Epilepsy: Y/N

Allergies____

Family Physician______________________________ Phone______________________

Current Medications____

☐ **Child Takes Medication on his/her own**

Past Serious Health Problems/ Other issues of which Mr. Kortyka should be aware:

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Medical Treatment Authorization

I, ______________________________, authorize the use of "over the counter" medications such as Tylenol, Pepto-Bismol, ointments, etc. to be administered to my child when needed.

____
Parent/Legal Guardian Signature

I, ______________________________, authorize treatment of my child by a medical professional or by a hospital for any medical emergency.

Preferred Hospital: ____

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Parent/ Legal Guardian Signature

PHOTOCOPY INSURANCE CARD HERE IF POSSIBLE