Alpharetta High School Bands - Medical Form   DATE: _______________

Student's Name: ____ Date of Birth: ________________

Parent / Guardian Name: ____ Home phone: ____________

Home Address:____ Zip: ______________

Dad cell ________________________________ Work Phone:______________________________

Mom cell ________________________________ Work Phone:______________________________

Date of last Tetanus Booster: ___________________________

Primary Physician's Name: ___________________________________ Phone #: ______________

Please list all known allergies: *(food, insects, medications, etc. Attach separate sheet if needed.* ***If none, please state.****)*

Please list any specific medical problems: *(Attach separate sheet if needed.* ***If none, please state.****)*

List any medication the student is currently taking & its purpose: (*Please* give details regarding amount, timing and manner of taking. *Attach separate sheet if needed.* ***If none, please state.*** **If student carries a prescription Inhaler, Epipen, Insulin or other approved medication, they must fill out a Student Health Services SHS-2 Form and attach to this medical form**.*)*

Emergency Contact Information – In the event you can't be reached, please list 2 people *other than you that* we may contact in case of an emergency.

1. Name: __________________________________ Relationship: ____________________________

   Home phone: ______________________________ Cell phone: ______________________________

2. Name: __________________________________ Relationship: ____________________________

   Home phone: ______________________________ Cell phone: ______________________________

Insurance Information (a photocopy of your insurance card must be attached)

Insurance Company Name: ________________________________ Policy #: __________________________

Group Plan #: ______________________________ Carrier Phone #: ________________________________

For and in consideration of emergency services and goods rendered through the attending physician(s), the undersigned hereby guarantees payment in full immediately upon receipt of final billing.

Name of Responsible Party (print name): ____ Date ___________

Signature of Responsible Party: ____ Date ___________

Consent for Medical Treatment

TO WHOM IT MAY CONCERN: I, the undersigned, being the parent, legal guardian, or legal next of kin of _______________________ _______________ (student's name), hereby grant authorization to the Band Director (s) or any chaperone of the Alpharetta High School Band Booster Association, standing in loco parentis (in the event that a parent/guardian cannot be reached by phone), to obtain any medical and/or surgical treatment and procedures from a physician or hospital emergency room physician on behalf of the above named minor. I also grant permission to administer over-the-counter medication as needed.

Print name of person giving consent____ Date________________

Signature____Relationship_____________________

Witnessed by: ____

Notary ____________________________________ Date: ________________________

NOTES: This form must be completed in full and returned with ***A PHOTOCOPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD, A COPY OF YOUR MOST RECENT PHYSICAL, SHS-2 Form (if applicable) AND THE LIABILITY RELEASE FORM***.

REVISED: 4/2012