

ELIZABETHTON HIGH SCHOOL BAND  
Elizabethton, Tn.  
**PERMISSION FOR MEDICAL TREATMENT**

TO WHOM IT MAY CONCERN: I, the undersigned, being the parent, legal guardian or legal next-of-kin of:

\_\_\_\_\_  
(FULL NAME OF STUDENT)

hereby authorize any necessary medical treatment for this person while participating in band activities. I also guarantee payment of all charges incurred during the treatment. ( Ambulance, physician, hospital, X-ray, lab, drugs, etc. )

In regard to such person, I submit the following information:

1. ALLERGIES TO FOODS, MEDICATION, etc. ( If NONE so state, if YES specify )

\_\_\_\_\_

2. SPECIAL MEDICAL PROBLEMS ( If NONE so state, if YES specify ) :

\_\_\_\_\_

3. Is the student now under medical care? \_\_\_\_\_

If so, describe the nature of illness and treatment \_\_\_\_\_

\_\_\_\_\_

4. Does participant carry medication on person? \_\_\_\_\_

( If NONE, so state ) Name of medication: \_\_\_\_\_

Purpose: \_\_\_\_\_

5. Date of last tetanus. \_\_\_\_\_

6. Family physician /  
clinic \_\_\_\_\_

Phone \_\_\_\_\_ Office address \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Print or type name of person signing \_\_\_\_\_

Relation of person signing \_\_\_\_\_

Residence address \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business / Mother \_\_\_\_\_

Business / Father \_\_\_\_\_

Emergency name and number if above not available (please print): \_\_\_\_\_

\_\_\_\_\_ phone \_\_\_\_\_

7. Insurance Company \_\_\_\_\_ I.D. # \_\_\_\_\_