Joliet Township High Schools

Student Medical and Treatment Authorization Form

Student Information

(Please print) Student Name _____ Grade:

Birth Date _____

Home Address _____ City _____ State _____ Zip _____

Telephone Numbers: Home (____) _____ Student cell (____) _____

Email addresses: Parents _____

Student _____

Emergency Contact and Parent/Guardian Information:

1st Contact: _____ Relationship _____

Address (if different from above) _____ email _____

Home (____) _____ Work (____) _____ Cell (____) _____

2nd Contact: _____ Relationship _____

Address (if different from above) _____ email _____

Home (____) _____ Work (____) _____ Cell (____) _____

Treatment Authorization To be completed by Parent or Guardian

In the event I cannot be reached in an emergency, I hereby authorize Mr. Eric Wellman, Ms. Alyson Bauman, or their 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.

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 West Administration and JTHS School Board.

Dated: _____ Signed: _____ (parent/guardian)

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