Singing Sensations Youth Choir

Medication and Treatment Authorization

Choir Member Name _____ Birth Date ___ / ___ / ___

Parent/Guardian's Full Name_____

Medical Insurance Company: _____ Group # _____

Policy # _____ Policy Holder's Name _____

Family Physician: _____ Phone _____

Emergency Notification Person if parents cannot be reached (Please list two):

_____
Name and Phone Number

_____
Name and Phone Number

Please list any special health problems, allergies and expected reactions, learning disabilities, recent injuries or chronic conditions requiring nursing care (e.g. casts, dressings, sprains, asthma, etc.):

_____

Please list any medications being taken: _____

I authorize the designated SSYC nurse, physician, chaperones or staff to administer the following prescription medications:

Medication:_____ Instructions: _____

____ My initials herewith give my permission for dispensing over the counter medicines (Tylenol, Tums, Ibuprophen, et. al) as deemed necessary by the SSYC staff or designated medical person.

In the unlikely event that my child becomes ill or is injured and I or the authorized physician named above cannot be immediately contacted at the time of an emergency and, if in the judgment of the SSYC staff, immediate observation or treatment is necessary, I authorize and direct the staff to send my child (properly accompanied) to the hospital or physician most easily accessible. I release the Singing Sensations Youth Choir, Inc. from any claim of liability in connection therewith.

_____

Signature of Parent/Legal Guardian Date