**REVERE MUSIC DEPARTMENT MEDICAL AUTHORIZATION FORM**

STUDENT NAME_____

ADDRESS_____

CITY _____ZIP_____

HOME PHONE (____) _____

Email address, for office use only

_____

Mother

_____

Father

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/ guardian cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN

MOTHER'S NAME _____DAYTIME PH# (____) _____

CELL PH# (____) _____

FATHER'S NAME _____DAYTIME PH# (____) _____

CELL PH# (____) _____

OTHER'S NAME_____DAYTIME PH# (____) _____

RELATIONSHIP_____ CELL PH# (____) _____

**MUST BE COMPLETED FOR CONSENT**

I hereby give consent for the following medical care provider and local hospital to be called when applicable:

DOCTOR_____ PH# (____) _____

DENTIST_____ PH# (____) _____

MEDICAL SPECIALIST_____ PH# (____) _____

LOCAL HOSPITAL (____) _____ EMERGENCY RM. PH# (____) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**MEDICAL HISTORY**

Please list medical history including ALL allergies, medications being taken and any physical impairments.

_____

_____

_____

SIGNATURE OF PARENT/GUARDIAN_____DATE_____