

Jenks Public Schools

Instrumental Music Department
2015-16 Medical Consent Form

We, the undersigned parent(s) or legal guardian(s) of the minor child listed below:

Student Last Name	Student First Name	Student ID	Date of Birth
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do hereby authorize any hospital service, x-ray, examination, anesthetic, dental, medical or surgical diagnosis or treatment by any licensed physician or dentist, and hospital service that may be rendered to said minor or minors under the general, specific or special consent of Jenks Instrumental Music Department, the temporary custodians of the minor.

I/We authorize the physician or dentist to call in any necessary consultants in his/their discretion. I/We also authorize a Jenks Band director or parent sponsor to administer my child's prescription medication and over-the-counter medication to my child (such as but not limited to Tylenol, Neosporin, or Benadryl) as necessary while in their custody without liability.

It is understood that the consent is given in advance of any specific diagnosis or treatment being required but is given to encourage those persons who have temporary custody of the minor or minors and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment. This consent shall remain effective until 3 p.m. on the 1st day of June, 2016 unless sooner revoked in writing and delivered to said physician or dentist or said persons entrusted with the custody, care and control of said minor child.

Known Medical Conditions/Allergies to Medications:

Known Allergies to Foods:

Current Over -the-Counter Medications:

Current Medications	Dosage	Frequency	Ongoing (Yes/No)

Health Insurance #1:

Company Name _____
 Insured's Name _____
 Telephone Authorization # _____
 Policy # _____
 Group # _____

Health Insurance #2:

Company Name _____
 Insured's Name _____
 Telephone Authorization # _____
 Policy # _____
 Group # _____

Student's Physician		Student's Dentist	
Phone #		Phone #	

Emergency Contact Name	Primary Phone	Secondary Phone	Medical Insurance
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Parent/Guardian #1 Name	Cell Phone	Home Phone	Signature
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Parent/Guardian #2 Name	Cell Phone	Home Phone	Signature
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Signed this _____ day of _____, 2015