Valhalla Marching Band & Color Guard
Richard Almanza, Director

# AUTHORIZATION TO RENDER MEDICAL, DENTAL, SURGICAL OR HOSPITAL CARE TO A MINOR

(Please complete and return to Mr. Almanza)

Dear Parents or Guardians:

It will be to everyone's advantage if you will make a complete and frank statement of your child's health. Include anything which will require special attention as well as a list of drugs (including aspirin) to which he or she may be allergic or should not be given.

The following is a list of diseases and/or conditions which may pertain to your student. State the age at which it occurred. If condition has never existed, write "None". List any additional information which might be helpful.

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| Appendicitis | ________ | Hay Fever | ________ | Asthma | ________ |
| Heart Disease | ________ | Chronic Cough | ________ | Mononucleosis | ________ |
| Constipation | ________ | Rheumatic Fever | ________ | Diabetes | ________ |
| Tonsillitis | ________ | Ear Infection | ________ | Pneumonia | ________ |
| Epilepsy | ________ | Motion Sickness | ________ | Fainting | ________ |

Other (describe thoroughly) ____________________________________________________
______________________________________________________________________

Is the student taking any medication regularly or periodically? Yes_________ No_________
If "Yes", what? ______________________________________________ How often? ___________
Be sure to thoroughly discuss the medication, the dosage, and the condition for which is prescribed with the chaperone/chairpersons.

## STATEMENT OF AUTHORIZATION

The UNDERSIGNED parent or legal guardian of ___________________________________, a minor, hereby authorizes Mr. Almanza, Director and Color Guard Advisor, and/or an authorized chaperone, to consent to any and all medical treatment to be rendered to said minor under the supervision and upon advice of a physician, surgeon, or dentist licensed under the provision of a State Medical Dental Practice Act. This authorization shall remain effective until the end of the school year or sooner if revoked by the undersigned in writing and delivered to Mr. Almanza, or the Valhalla High School Administration.

Parent(s)/Guardian(s) (print)_______________________________________________

Address_________________________________ City_______________ Zip_________

Home Telephone______________________ Alternate Phone____________________

Student's Birth Date ________________

PRESENT INSURANCE COMPANY_________________________________________

Family Doctor's Name______________________ Telephone______________________

**Parent(s)/Guardian(s) Signature_____________________________ Dated_________**

Witnessed By__________________________