NORTHGATE HIGH SCHOOL
INSTRUMENTAL MUSIC DEPARTMENT MEDICAL RELEASE FORM

I, the parent (guardian) of _____, a minor, grade _____ , date of birth _____, do consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until revoked in writing and delivered to said agent(s).

Dated _____

X_____ _____ _____ _____
Father/Legal Guardian Signature **Home Phone** **Cell Phone** **Work Telephone**

X_____ _____ _____ _____
Mother/Legal Guardian Signature **Home Phone** **Cell Phone** **Work Telephone**

Person other than parent who may be contacted:

1. **Name** _____ **Address** _____ **Phone** _____

2. **Name** _____ **Address** _____ **Phone** _____

SPECIAL INFORMATION:
Does the student have any condition which might be the cause of a medical emergency?
(ie. Diabetes, fainting spells, drug allergies, medication requirements, etc.)

_____

_____

Date of last tetanus shot: _____ Any known allergies: _____

Primary Physician: _____ Telephone: _____

Insurance Carrier: _____ Telephone: _____

Policy Number: _____ Medical Number: _____

Is student required to take medication? YES ____ NO ____

If YES, name of medication(s):_____ Times to be taken: _____