Medical History & Emergency Consent Form

Student Name (Please Print): ____

Please provide below information that will help our staff obtain medical assistance for your child in the case of accident or illness.

1. Are they currently receiving, or have they recently received any medical or psychological care, or any other treatment, of which you want us to be aware in case of an emergency? If so, describe fully.

____
____
____

2. What medications or other substances are they allergic to?

____

3. Are there any medications they are currently taking that SDCYB staff should be aware of?

____

4. Do you have a physician who should be consulted in case of an emergency? If so, list below.
Physician Name Phone (____) ____-______ Ext. _____

5. Insurance Company: ___________________________________ Policy #: _________________________

5. Please provide an emergency contact: ____
Phone (daytime): ___________________________ Phone (Cell): ________________________________

M E D I C A T I O N A D M I N I S T R A T I O N

Non-prescription Medication listed below is available in the Clinic for parents to request for their child. This medication is given *after* initial evaluation of your child's symptoms. All medications are given in accordance with the packaging label on the product, by age and weight-appropriate strengths. I hereby authorize SDCYB staff to administer medication checked below to my child while at SDCYB.

[ ] No medications may be administered
[ ] Acetaminophen (e.g. Tylenol) for fever or pain
[ ] Antibiotic ointment (e.g. Neosporin) for cuts and scrapes
[ ] Throat Lozenges (e.g. Halls cough drops)
[ ] Benadryl Liquid (for severe allergic reactions)
[ ] Ibuprofen (e.g. Advil, Motrin) for fever or pain

I (we) the undersigned parent(s) or guardian(s) of ____ a minor, do hereby authorize and consent to an X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable and is to be rendered under the general or special supervision of any medical or emergency room staff licensed under the provisions of the Medical Practice Act. I (we) agree to accept responsibility for all costs incurred from the rendering of needed emergency services for my (our) child.

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 consent to such care when the foregoing licensed physician in his/her best judgment deems it advisable. It is understood that the hospital shall attempt to contact the undersigned and the physician identified above if one is noted, prior to rendering treatment to the minor or dependent adult.

In the event that I (we) can not be reached, my (our) authorization is given to the responsible party from SDCYB to secure proper treatment for my child named above.

I (we) agree to save and hold the officers, employees, or agents of the San Diego Civic Youth Ballet and the medical care providers harmless from all liability, suits, or claims, of whatever nature or kind which might arise as a result of administering needed emergency care.

***Guardian Signature*: ____ *Date:* ____________**