Ambridge Area Band Boosters, Inc 2021-2022

Parent Authorization of Consent to Treatment of Student

Name of Student: (Last) (First) (Middle)	Date of Birth	Grade

As a parent(s)/ guardian(s) of the above-named student, a minor, I/We do hereby authorize a Ambridge Area School District staff member(s), to act as my/our agent(s), to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and/or hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/ surgeon or at a hospital.

I hereby authorize you to use or disclose the specific information included on my son/daughter's medical information form as outlined below. The Ambridge Area Band Boosters, Inc. are permitted to disclose any of the information contained on this form to any School Nurse, First Responder, Paramedic, Ambulance, Attendant, Hospital, Nurse or any other Medical Service that is summoned in the event my child needs medical assistance.

It is understood that I/we must assume legal responsibility for any expenses incurred for medical treatment which my not be covered by my/our personal insurance, Medicaid, or Medicare.

Name of Father/ Guardian: (Last) (First) (Middle)	
Best Phone number to reach Father- Circle one and enter number	Work Home Mobile #
Name of Mother/ Guardian: (Last) (First) (Middle)	
Best Phone number to reach Mother- Circle one and enter number	Work Home Mobile #

I/we may amend or change this form at any time providing a new authorization form is submitted.

I /we may revoke this authorization by notifying the organization in writing to AABB Inc. PO Box 145, Baden, PA 15005

Information used or disclosed as outlined above may be passed through various individuals during the course of treatment

I/we may refuse to sign this authorization. I/we understand that in doing so, appropriate measures will be taken to aid my child if necessary, however any information disclosed to Ambridge Area Band Boosters, Inc. will not be disclosed to any personnel treating my child.

Does your child have a history of high blood pressure, diabetes, concussion, asthma, musculoskeletal condition, fainting spells, seizures? ((Circle all that apply) List any other health conditions your child currently has or any recent hospitalizations:

List any medications your child is taking:

List any allergies your child has: (drug, environmental, and food)

The chaperone representative or nurse has my permission to dispense to my child: ◯Tylenol ◯Ibuprofen ◯Advil ◯Aleve ◯Tums ◯Pepto-Bismol ◯Cough Drops ◯Benadryl ◯Advil ◯Suntan Lotion (You must X all that you give permission for)

I/we have read and understand the extent of this authorization and that it shall remain effective until the end of the current school year, from August 1, 2020 through July 31, 2021. Any updates to this information are the responsibility of the parent/ guardian to notify Ambridge Boosters Inc.

Signature of Parent/ Guardian	Date	Email Address:	

Insurance Information

Doctor's Name	Phone number:
Name of Inured Policy holder: (Last/First/ Middle)	
Billing Address of the Policy Holder: Street City State Zip	
Insurance Company	◯HMO ◯PPO ◯Medicaid ◯Medicare ◯other
Group Number	Policy Number