MEDICAL TREATMENT AUTHORIZATION AND CONSENT
Great Lakes Wind Symphony and Affiliates
Youth Wind Symphony and Summer Winds Camps
23 Grant Street
Wellsboro, PA 16901

I, _____, being the parent/guardian of _____ authorize the GLWS staff to seek, obtain and consent to routine medical care and treatment, emergency medical care and treatment, for any injuries obtained while participating in activities of the GLWS music camps or youth wind symphony as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child under the supervision of the GLWS and its affiliates, and is effective for as long as my child is participating in the activities for which they are registered,

Child's Information

Child's Full Name: _____

Address: _____, PA _____

Date of Birth: (00/00/XXXX)_____ Age: _____ Sex: _____

Child's Health Information

Health Conditions: (List; e.g. Diabetes, Heart Issues, ADHAD, ASD, Anxiety, etc.)

Allergies: (List all: Food and Other)

Prescription Medications: (List all, dosages, and schedule)

Will they need to take these Prescription Medications during their time under our supervision? yes/no

Do they need Assistance/Supervision Taking Prescription Medication: Yes/No Date

of Last Tetanus Injection/Booster: _____

Child's Medical Care Information

Physician/Pediatrician: _____ Phone Number: _____

Insurance Company: _____

Policy/Group Number: _____ Policy Holder: _____

Parent's Information

Parent's Name: _____

Address, _____, _____PA _____

Phone Number (H): _____ **Cell(C):** _____

Phone Number (W): _____ **Email:** _____

Emergency Contact Person's Information

Emergency Contact's Name: _____

Phone Number (H): _____ Phone Number (C): _____

Phone Number (W): _____ Email: _____

Signature of Parent

Signature

_____

Print Name Date

_____ _____ _____