

**SCHOOL OF SCOTTISH ARTS
MEDICAL INFORMATION AND INFORMED CONSENT FOR
TREATMENT**

Student's Name _____

PLEASE READ AND COMPLETE THE FOLLOWING FORM.

I. Medical Information

Known allergies to foods, drugs, insect stings or bites, etc:

Special medical concerns or conditions that event supervisors should know about, including contagious illnesses, epilepsy, asthma, diabetes, previous injuries to bones/joints, etc.:

List special dietary needs:

Medications currently being taken (name of medication, dose, and frequency):

Family Physician: Name _____ Phone # (____) _____
Address _____

II. Insurance Information

Health Insurance Company

Health Insurance Policy #

Company Address

Company Telephone Number (____) _____

Signatures Acknowledging Parts I and II

Parent's/Guardian's signature _____ Date: _____

Parent/Guardian telephone #: Home _____ Work _____

Parent/Guardian cellphone #: _____ Email _____

Please attach a copy of both sides of your insurance card.

III. Informed Consent

In the event that a student needs minor medical care from SSA or more significant medical care from a qualified health care provider, including in rare cases possible hospitalization and/or surgery, the parent/guardian is asked to sign the informed consent form below. In case of serious medical condition, SSA will make every effort to notify the parents, but the first priority may be providing care to the student.

Authorization to Consent to Health Care for Minor

I, _____, of _____ County, am the custodial parent having legal custody of _____, a minor child, age _____, born _____. I authorize any adult(s) acting as agents (including official volunteers) the School of Scottish Arts and in whose care the minor child has been entrusted, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person for such health care, and ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

This consent shall be effective for the duration of the School of Scottish Arts in 2011.

Custodial Parent Signature _____ Date _____

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20____, personally appeared before me the said named, _____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledged that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

My commission expires _____, 20_____.

Notary Public

(OFFICIAL SEAL)