



2019-2020

## Medication and Treatment Authorization

Chorister's Full Name \_\_\_\_\_

Birth date \_\_\_ / \_\_\_ / \_\_\_\_\_

Parent/Guardian's  
Full Name \_\_\_\_\_

Emergency Notification Person if parents cannot be reached (Please list two):

\_\_\_\_\_

Name and Phone Number

\_\_\_\_\_

Name and Phone Number

Please list any special health problems, allergies and expected reactions, learning disabilities, recent injuries or chronic conditions requiring care (e.g. casts dressings, sprains, asthma, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Please list any medications being taken:

\_\_\_\_\_  
\_\_\_\_\_

In the unlikely event that my child becomes ill or is injured and I cannot be immediately contacted at the time of an emergency, and if in the judgment of the director/staff of the Bend Children's Choir immediate observation or treatment is necessary, I authorize and direct the director/staff to send my child (properly accompanied) to the hospital or physician most easily accessible. I release The Bend Children's Choir and COCC from any claim of liability in connection therewith.

\_\_\_\_\_  
Signature of Parent/Guardian/Responsible Adult

Date \_\_\_/\_\_\_/\_\_\_\_\_

Note: one chorister name per form. Please bring hard copy to first rehearsal.