CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MINOR
KANSAS YOUTH CHORALE

Singer's Name: ____Birthday: ________________

Medications child is taking: ____

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Allergies (include all known allergies, such as food and drugs):

____

Name of parent/guardian: ____

Address: ____

Home phone: ___________________Work phone: _____________________Cell phone: ________________

Name of person(s) who will know the location of a parent at all times: _____________________________

Relationship of this person to parent: ____

Home phone: ___________________ Work phone: __________________ Cell phone: __________________

Family Physician: _______________________________________ Office phone: ____________________

If we cannot locate you by any of the above means, whom would you like us to notify in the event of illness or accident to your child?

Name: ____ Phone: ______________________

Relationship to parent/guardian: ____

If your child needs to be taken to a hospital emergency room, they will require the following:

Which hospital ER? ____

Insurance Company: ____

Policy Number: ___________________________________ Policy Holder: _________________________

EMERGENCY TREATMENT AUTHORIZATION: In the case of a medical emergency involving the minor listed, I request the doctor/dentist/hospital staff to contact me (or my spouse) at the numbers provided. In the event that I (or my spouse) cannot be reached, I grant written permission to any member of Kansas Youth Chorale staff to authorize the appropriate medical/dental/hospital personnel to render emergency medical or dental care as deemed appropriate. I (we) agree to pay for the normal and customary charges of the hospital and for any treatment or medication received by said child. (Signatures of both parents are preferred if possible.) **Print this page, complete it, and bring it to the Retreat on Aug. 24

Signature of Parent (s)____

Witness: ____________________________________ Date: ______________________________