Cab Calloway School of the Arts
High School Band Program

PARENTAL CONSENT STATEMENT

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating the above-named child, I also hereby consent to any treatment, surgery, diagnostic procedure, or the administration of anesthesia as may be deemed necessary by such physician, dentist or surgeon. I further understand that I am giving temporary custodial authority to James F. Tharp or designated Color Guard/ Percussion Ensemble Instructors, and that he/she is acting at my request in this capacity for the purposes of such consent to emergency medical and or dental treatment (after the aforesaid procedures have been followed, see below). I further understand and agree that the Red Clay Consolidated School District is not liable for any of the expenses of such treatment and that I will reimburse and save harmless said District for any expenses it incurs for any such treatment.

Student Name: ____

____ _______________
Signature of Parent/Guardian Date

Parental Notification Procedures in the Event of a Medical Emergency

The Red Clay School District had adopted the following policy in caring for your child when he/she becomes injured at school or at a school function.

In case of emergency and the need for medical or hospital care:

1. The school will call home. If there is no answer,
2. The school will call the father/ mother’s place of employment. If no answer,
3. The school will call the emergency telephone number listed.
4. If none of the above answer, the school will call an ambulance to transport the child to a local hospital.
5. The child will be admitted to the hospital, and the school will continue to telephone the parents until they are reached.

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EMERGENCY TREATMENT DATA

STUDENT NAME____
Last First Middle

DATE OF BIRTH_________________________

HOME ADDRESS____

HOME PHONE___________________________

FATHER'S NAME & PLACE OF EMPLOYMENT____

PHONE________________________________

MOTHER'S NAME & PLACE OF EMPLOYMENT____

PHONE________________________________

IF PARENTS CANNOT BE REACHED, CALL____

PHONE________________________________

FAMILY DOCTOR____________________________________ PHONE_____________________________

FAMILY DENTIST___________________________________ PHONE_____________________________

Student is subject to or has a history of:
( ) heart trouble ( ) epilepsy ( ) diabetes ( ) other_________________________________

Student is allergic to:
( ) morphine ( ) penicillin ( ) sulfa drugs ( ) aspirin
( ) other____________________________

Medical Insurance Company Name ____

Medical Insurance Policy #____