



Medication and Treatment Authorization ___ Debut ___ Premiere ___ Singers School

Full Name _____ Birthdate ___ / ___ / ___

Parent/Guardian's Full Name _____

Medical Insurance Company: _____ Group # _____

Policy # _____ Policy Holder's Name _____

Family Physician: _____ Phone _____

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 nursing care (e.g. casts, dressings, sprains, asthma, etc.):

Please list any medications being taken:

I authorize the designated YCCO nurse, physician, chaperones or staff to administer the following prescription medications:

Medication: _____ Instructions: _____

I give my permission for dispensing over the counter medicines (Tylenol, Tums, Ibuprophen, etc.) as deemed necessary by the YCCO staff or designated medical person: ___Yes___No

(Please use the reverse side for additional information if needed.)

In the unlikely event that my child becomes ill or is injured and I or the authorized physician named above cannot be immediately contacted at the time of an emergency, and if in the judgement of the staff of the Youth Choir of Central Oregon immediate observation or treatment is necessary, I authorize and direct the staff to send my child (properly accompanied) to the hospital or physician most easily accessible. I release the Central Oregon Singers Inc./Youth Choir of Central Oregon from any claim of liability in connection therewith.

Signature of Parent/Guardian/Responsible Adult:

Date