



**EMERGENCY CONTACT, MEDICAL INFORMATION AND  
AUTHORIZATION FOR MEDICAL CARE**

---

**Program Name:** KSU GMEA All-State Band Audition Clinic

**Date(s) of Program:** Saturday, December 7, 2019

**Participant Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Participant Gender:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

---

**Emergency Contact Information**

**Emergency contact name and phone number:** \_\_\_\_\_

**Relationship to Participant:** \_\_\_\_\_

**Backup emergency contact name and phone number:** \_\_\_\_\_

**Relationship to Participant:** \_\_\_\_\_

---

**Health Insurance Information (if available)**

**Insurance Provider:** \_\_\_\_\_ **Insurance Phone Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Physician/Pediatrician Practice:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

*(Note: Kennesaw State University does not offer any form of health, liability, or other types of insurance for participants. If available, please attach a copy of the front and back of your insurance card with this form.)*

---

**Medical Information**

1. Medical information we need to know about Participant (current conditions, physical limitations, past injuries, etc.): \_\_\_\_\_

---

---



**EMERGENCY CONTACT, MEDICAL INFORMATION AND  
AUTHORIZATION FOR MEDICAL CARE**

2. Allergies (medications, stings, foods, iodine, latex, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Medications Participant is currently taking, dosage, and times taken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Date of last Tetanus shot: \_\_\_\_\_
5. Does your child need any accommodations to safely participate in the program? \_\_\_\_\_ If yes,  
please explain: \_\_\_\_\_  
\_\_\_\_\_

---

**KSU Administration of Medication**

KSU faculty, staff and volunteers are not equipped to administer medications to Participants. All participants should be able to administer their own medications.

---

**Authorization for Medical Treatment**

I consent to medical and/or surgical care as may become necessary for the Participant's well-being, should the need arise, and I understand that I will be solely responsible for the cost. I authorize Kennesaw State University to communicate in emergencies with the person(s) identified in my submission materials. I hold harmless and agree to indemnify Kennesaw State University from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment.

By signing this form, I agree that all information is accurate and current, that all important information is listed on this form, and to the best of my knowledge, my child is capable of participating safely in the Program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program of any changes in the above information as soon as possible.

---

**Signature of Parent/Guardian:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_