EMERGENCY CONTACT, MEDICAL INFORMATION AND AUTHORIZATION FOR MEDICAL CARE

Program Name: KSU Brass Blast

Date(s) of Program: February 22, 2020

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.):_____

_____

_____

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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: _____