

# 2012 Lions All State Band Medical Release



Band Member Name: \_\_\_\_\_

If your child needs medical care, dental care or hospital services, you as parent/guardian must give permission. **IT IS THE LAW!** In an emergency, your child can only be treated without your consent if a physician determines that your child's life or health is at risk. Unless a true emergency exists, medical personnel are powerless to help your child without your authorization. That is why you complete this **Medical Treatment Authorization** form today. You can prepare for the unexpected by giving other adults permission to authorize necessary treatment for your child during your absence. By filling out the form, you may legally appoint anyone over 18 years of age – relatives, teachers, babysitters, and friends – to take is responsibility. **Complete this form carefully, and have your signature witnessed by a Notary Public.** The original must be on file before your child is allowed to participate in the Mississippi Lions All State Band Program.

I, \_\_\_\_\_ and \_\_\_\_\_, Legal parent(s)/Guardian(s) of \_\_\_\_\_ authorize:

**Jeff Cannon**  
Director/Manager  
12480 Lebanon Pinegrove Road  
Terry, MS 39170  
601-878-9939

**Micky Mangum**  
Assist. Director/Manager  
206 Bruenburg Parkway  
Clinton, MS 39056  
601-925-5766

**James Cagle**  
Registered Nurse  
431 Katherine Drive  
Flowood, MS 39232  
601-420-5739 x 100

To act on my/our behalf in authorizing unexpected medical, dental, surgical care or other appropriate representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent Guardian \_\_\_\_\_  
(Please PRINT)

Signature \_\_\_\_\_

Address: \_\_\_\_\_

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

Parent Guardian \_\_\_\_\_  
(Please PRINT)

Signature \_\_\_\_\_

Address: \_\_\_\_\_

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

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR:  
Insurance or Government Program:

\_\_\_\_\_ I.D or Contract Number \_\_\_\_\_

Notary Public:

The above parent(s)/Guardian(s) personally appeared before me on \_\_\_\_\_.

Notary Signature: \_\_\_\_\_ . My Commission Expires \_\_\_\_\_.

(Affix seal or stamp here)

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## Authorization for Medical Treatment of Minors

Band Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Drug Allergies:  NO KNOWN DRUG ALLERGIES

Family Physician: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Physician Phone Number: ( ) \_\_\_\_\_

### Medications:

### Reason Medication Taken:

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

5. \_\_\_\_\_

\_\_\_\_\_

6. \_\_\_\_\_

\_\_\_\_\_

7. \_\_\_\_\_

\_\_\_\_\_

8. \_\_\_\_\_

\_\_\_\_\_

9. \_\_\_\_\_

\_\_\_\_\_

10. \_\_\_\_\_

\_\_\_\_\_

### Medical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Surgical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Special Needs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_