

Kentucky Band Camp Medical Treatment Authorization

Student's Name _____

Consent for treatment for students under 18 years of age.

The undersigned parent or guardian grants authority to the **University of Kentucky Medical Center** and its staff to perform those procedures and treatments deemed necessary for the student named above, and as are generally used in the care of patients in this and similar hospitals and clinics. The undersigned also agrees to financial responsibility for procedures and treatment administered to his/her child at the **UK Medical Center**.

Parent or Guardian

Address

Telephone

Does your son/daughter have any chronic medical problems that would suggest that he/she keep medicine(s) on person? If so, describe the medical problem:

What medication is normally kept on his/her person?

Is your son/daughter covered by Health or Accident Insurance?
If so, complete below and send a photocopy of the insurance card.

Company _____

Policy No. _____

***THIS COMPLETED FORM MUST BE BROUGHT
TO THE REGISTRATION TABLE.***