

USD #385  
DEPARTMENT OF HEALTH SERVICES  
APPOINTMENT OF AGENT FOR  
CONSENT TO TREATMENT FOR EMERGENCY CARE

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_, do hereby consent to any hospital, medical or surgical care and treatment, and the administration of anesthesia, determined by a qualified physician to be necessary for the welfare of my child while said child is under the care, custody and control of Andover Central High School Band, and I am not reasonably available by telephone to give consent.

State of \_\_\_\_\_

County of \_\_\_\_\_

Signed or attested before me on \_\_\_\_\_ Date

by \_\_\_\_\_ Parent/Legal Guardian Signature

\_\_\_\_\_ Signature of Notary

\_\_\_\_\_ Title

My appointment expires: \_\_\_\_\_

THIS ADDITIONAL INFORMATION WILL ASSIST IN TREATMENT IF IT CAN BE FURNISHED WITH THE CONSENT BUT IS NOT REQUIRED:

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

Telephone Numbers:

Father at Work: \_\_\_\_\_ at Home: \_\_\_\_\_

Mother at Work: \_\_\_\_\_ at Home: \_\_\_\_\_

Other Emergency Contacts: Cellular Phone: \_\_\_\_\_

Pager: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last Tetanus: \_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_

Allergies to Drugs: \_\_\_\_\_

Allergies to Foods: \_\_\_\_\_

Special medical treatments: \_\_\_\_\_

Significant current/past medical conditions (Please list and explain) : \_\_\_\_\_  
\_\_\_\_\_

Family physician: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Phone

No.: \_\_\_\_\_

Must we call your insurance company or physician prior to any medical treatment?