

# SUMMER DANCE LAB

Whitman College

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## 2009 CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT DURING ABSENCE OF PARENT OR LEGAL GUARDIAN

During my absence or in the event that I cannot be reached immediately, I acknowledge that necessary medical care may be administered to:

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Number of weeks attending (check one): \_\_\_\_\_(2 wks) \_\_\_\_\_(3 wks) \_\_\_\_\_(5 wks)

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

Medical Conditions being treated \_\_\_\_\_

### List of Current Medications:

1. \_\_\_\_\_ Dosage: \_\_\_\_\_
2. \_\_\_\_\_ Dosage: \_\_\_\_\_
3. \_\_\_\_\_ Dosage: \_\_\_\_\_
4. \_\_\_\_\_ Dosage: \_\_\_\_\_
5. \_\_\_\_\_ Dosage: \_\_\_\_\_

Allergies \_\_\_\_\_

Previous Injuries \_\_\_\_\_

I understand such treatment will be limited solely to those procedures deemed necessary by attending physician to treat properly: 1) emergency conditions, and 2) conditions which may be less than life threatening but which nonetheless require prompt attention and care.

This authorization and consent shall be valid for the entire SDL program.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian Signature)