Mu Phi Sigma National Percussion Fraternity, Inc.

Mu Phi Youth Society

Membership Application

Please Print or Type:

Date _____ Chapter: _____ Region: _____

First Name: _____Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel #: _____ Email address: _____

Date of Birth: _____Age: _____Gender: Male___ Female____

Name of School (If Applicable): _____ Grade: _____

Parent/Guardian Name: _____Relationship: _____

Address: _____ City_____

State_____ Zip: _____

Contact (Main): _____ (Cell): _____(Wk): _____

Reason for joining: _____

_____

Applicant Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

MU PHI YOUTH SOCIETY

EMERGENCY MEDICAL AUTHORIZATION FORM

Emergency Medical Authorization Form Purpose: To enable parents, guardians, alternate persons listed below, to authorize the provision of emergency treatment, including the administration of medication, for children who become ill or injured while under mentor authority, when parents or guardians cannot be reached.

Hosting Chapter:_____ Hosting Chapter President_____

_____ _____

Print name of M.P.Y.S member Date submitted (dd/mm/yyyy)

Residential Parent or Guardian:

Mother's Name: _____ _____
Last Name First Name

Mother's Contact: _____ _____
Work Cell

Lives with mentee: ___ Yes __ No

Father's Name: _____ _____
Last Name First Name

Father's Contact: _____ _____
Work Cell

Lives with mentee: ___ Yes __ No

Guardian's Name: _____ _____
Last Name First Name

Guardian's Contact: _____ _____
Work Cell

Lives with mentee: ___ Yes __ No

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EMERGENCY MEDICAL AUTHORIZATION FORM

IF THERE IS A COURT CUSTODY ORDER PERTAINING TO THIS CHILD, WHO HAS CUSTODY?

_____

First and Last Name

Alternative Person to Notify

Alternate # 1 Name: _____ Relationship_____

Address: _____ Home Phone _____

Cell Phone: _____ Work Phone _____

Alternate # 2 Name: _____ Relationship_____

Address: _____ Home Phone _____

Cell Phone: _____ Work Phone _____

Alternate # 3 Name: _____ Relationship_____

Address: _____ Home Phone _____

Cell Phone: _____ Work Phone _____

Alternate # 4 Name: _____ Relationship_____

Address: _____ Home Phone _____

Cell Phone: _____ Work Phone _____

Alternate # 5 Name: _____ Relationship_____

Address: _____ Home Phone _____

Cell Phone: _____ Work Phone _____

NOTE: NO CHILD will be released to the care of ANYONE unless his/her name appears on this form, or we receive written confirmation from parent or guardian using their given parental code for authorization. (This also includes an emergency situation)

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EMERGENCY MEDICAL AUTHORIZATION FORM

PART I or II MUST BE COMPLETED

Part I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called or transported to:

Physician: _____ Telephone _____

Dentist: _____ Telephone _____

Medical Specialist: _____ Telephone _____

Preferred Hospital: _____

Medical Coverage Information

_____

Health Insurance Carrier

_____

Health Insurance Policy # and Group #

_____

Personal Care Physician

_____

Address

_____

City/State/Zip Code

_____

Phone

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EMERGENCY MEDICAL AUTHORIZATION FORM

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Please provide the mentee's medical history, including allergies and medications being taken:

Medical condition(s) we should be aware of:

_____

_____

Medicine mentee is currently taking (amount/frequency/time taken):

_____

_____

Allergies Any other needed information regarding mentee:

_____

_____

*NOTE: This information will be shared with organization members who have a legitimate educational need to know.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent during this period.

_____ _____

Signature of Parent/Guardian Date

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EMERGENCY MEDICAL AUTHORIZATION FORM

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In cases in which the nature of an illness or an injury appears serious, the parent(s) are contacted and the instructions on this form are followed. In extreme emergencies, arrangements may be made for a student's immediate hospitalization whether or not the parent(s) can be reached. In the event of illness or injury requiring emergency treatment, I wish for the organization, Mu Phi Sigma National Percussion Fraternity, Inc., to take the following action(s):
(Please Print Clearly)

_____ _____

Signature of Parent/Guardian Date