

Permission for Medical Treatment

Please print legibly or type in PDF and print. You MUST sign the bottom.
Return to the Band Office by July 13, 2009

Last name: _____ First name: _____

Date of Birth _____

Family physician _____ Phone _____

My child is covered by a medical insurance program. yes ___ no ___

Insurance Co. name _____ Phone _____

Policy No. _____ Group No. _____

Insured's name _____ Insured's SSN _____

In regard to the person named above, I submit the following information (please attach a sheet if you need more room):

Date of last tetanus shot	
Food allergies	
Medication allergies	
Medical concerns	
Is student <i>now</i> under medical care? If yes, Please describe.	
Does the student take any prescription medications on a regular basis? If so, please list medication and condition being treated.	

Over-The-Counter (OTC) Medications are kept in the Band medicine bag at all times and travel with the Band everywhere. The following OTC medications will be dispensed as needed by a designated chaperone traveling with the Band. Please check either A or B below: (If neither is checked, NO OTC medications can be given)

___ A My Child can be given **any OTC medication** that is appropriate as determined by Mr. Blankenship, Band Director, or an adult chaperone.

___ B My child can ONLY be given the following medications. Please check yes or no beside each:

OTC Medications Available	YES	NO
Ibuprofen (Advil)		
Acetaminophen (Tylenol)		
Pseudoephedrine (Sudafed)		
Diphenhydramine HCL (Benadryl)		
Loperamide HCL (Imodium)		
Meclizine HCL (Dramamine)		
Calcium Carbonate (Tums)		

For any medications that need to be dispensed during a Band field trip, please notify Band Director Rob Blankenship or Band Booster lead chaperone. **Any changes in this information must be made IN WRITING to Mr. Blankenship.**

In the event I cannot be reached in a medical emergency, I hereby authorize any necessary medical treatment for _____ (student) while participating in the Douglas S. Freeman High School Band program. I also guarantee payment of all charges incurred during that treatment, including ambulance, physicians, hospital, x-ray, laboratory work, medications, etc.

Date _____ **Signature** _____