ALL INFORMATION ON THE FOLLOWING SHEET IS KEPT CONFIDENTIAL

2023-2024 Salem High School Band Medical Release Form

ALL INFORMATION IS REQUIRED IF APPLICABLE

Full Name: _____ Nick Name_____ *DOB*: ___/____/____

*Address*_____ *Grade*_____ *Age*_____

*City/Zip*_____/_____ *Home Phone:* _____

Work Phone(s) _____ *Cell Phone:* _____

*Emergency Contact (if parent not available):*_____ *Phone Number* _____
Relationship: _____
Insurance Company: _____ *Address:* _____

Policy Number: _____ *Phone:* _____

Name of Student's Physician:_____ Phone # _____

I give permission for my child's name and photo to be used on the band's Social Media: Yes____ No __

Signed:_____Date:___/_____/_____

Health History: All Information Required

Med Allergies: _____ Allergy to Bees/Insects ___ Yes or No ___
Food Allergies: _____ Does Student Carry an EPI PEN? ___ Yes or No___
Seasonal/Environmental Allergies: _____ Glasses or Contacts: ___ Yes ___ No (Circle which)
Asthma: ___ Yes ___ No Carry Inhaler? ___Yes ___No Use a Nebulizer at Home? ___Yes or No___

Previous injuries/illnesses: ___ Yes ___ No List _____

List Medical Conditions student currently/intermittently being treated (Diabetes, Crohns, IBS, Anxiety etc)

_____
If any additional information please list: _____

Medications: List all medications tat the student takes on a regular basis or any prescription medicine that may be needed in case of an emergency such as an inhaler or Epi-pen. These medicines must be sent to band functions in their original container with the doctor's instructions and given to the medical staff to administer. The student may keep the inhalers and Epi-pens after notifying the medical staff of this fact. We will be following the school medication policy as closely as feasible.

Medicine	Dose	Frequency

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FIELD TRIP PERMISSION FOR MEDICAL TREATMENT

I/we, the undersigned, give my/our child **permission to attend all band trips.**

I/we also give permission to John E. Wright and/or his appointed adult staff permission to care for or arrange for the health/ medical needs of my/our child while on any band function. This will include evaluation of need by the medical staff, administration of first aid, administration of any medications I/we have provided and are listed above, and emergency care and transport to a local Emergency facility for treatment if necessary. The medical staff for the band has my/our permission to administer the following over the counter medications as necessary according to the package labeling (these are stocked in the band first aid kit):

PLEASE REVIEW THIS LIST:
IF THERE ARE ANY YOU DO NOT WISH YOUR CHILD TO RECEIVE, WRITE "NO ON THAT BLANK

___Tylenol/Acetaminophen- headache/ pain

___Advil/Motrin/Ibuprofen/Aleve – headache/pain

___Benadryl (diphenhydramine)- allergies/ itching/ insect bites/stings

___Dramamine- motion sickness/nausea

___Throat lozenges- sore /hoarse throat

___Tums/Antacid- upset stomach/nausea

___ Allergy Medication (Zyrtec/ Claritan)-allergy symptoms

___ Allergy Eye Drops- itchy/runny eyes

___ Saline Eye Drops-dry eyes/Contacts

I/we understand that all reasonable efforts will be made to notify me/us as soon as possible of any emergency situations.

Date___/____/_____ Parent(s)/ Guardian(s) Signature:_____

Administration of Medications: (for medical staff use only)

Date	Time	Type of Medication/Dose	Reason	Administered by: