# ALL INFORMATION ON THE FOLLOWING SHEET IS KEPT CONFIDENTIAL 2020-2021 Salem High School Band Medical Release Form ALL INFORMATION IS REQUIRED IF APPLICABLE

Full Name:	Nick Name	Do	OB:/	
Address		Grade	Age	
City/Zip//	Home Phone:			
Work Phone(s)	Cell Phone:			
Emergency Contact (if parent not ava	nilable):Ph	one Number <sub>-</sub>		
Relationship: Insurance Company:	Address:			
Policy Number:	Phone:			
Name of Student's Physician:		Phone #		
I give permission for my child's na	ame and photo to be used on the	e bands Soci	al Media: Yes No	
Signed:		Da	te:/	
Hea	alth History: All Information Red	<u>quired</u>		
Med Allergies:  Food Allergies:  Seasonal/Environmental Allergies:  Asthma: Yes No Carry Inha  Previous injuries/illnesses: Yes	Does Studen Glasses or Co aler?YesNo Use a Nebul	t Carry an EP ontacts:	I PEN? Yes or No Yes No (Circle which) ?Yes or No	
List Medical Conditions student curre	ently/intermittently being treated (Γ	Diabetes, Croh	nns, IBS, Anxiety etc)	
If any additional information please li	ist:			
Medications: List all not that may be needed in case of an emerger functions in their original container with may keep the inhalers and Epi-pens after medication policy as closely as feasible.	the doctor's instructions and given to	ese medicines n the medical sta	nust be sent to band  off to administer. The student	
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	$\underline{\hspace{1cm}} Advil/Motrin/Ibuprofen/Aleve-headache/pain$
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 any emergency situations.	
Date/ Parent(s)/ Guardian(s) Signa	ture:
Administration of Medications: (for n	nedical staff use only)