

**FORT WALTON BEACH HIGH SCHOOL BAND**  
**MEDICAL RELEASE/INFORMATION FORM School Year 2020 – 2021**

This document is a Parent or Guardian's authorization for students traveling with the Fort Walton Beach High School Band.  
 This authorization is good for a period of one (1) year from date of signing.

Student Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Birthday \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Family Physician \_\_\_\_\_ phone \_\_\_\_\_

**Please list an emergency contact person in the event that you are unavailable.**

Name \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_

**May the Band Director or Nurse in charge give your child the following?  
 If left blank, medications cannot be given without parental consent.**

	YES	NO		YES	NO
Tylenol (for headache or pain).....	<input type="checkbox"/>	<input type="checkbox"/>	Dramamine (for motion sickness).....	<input type="checkbox"/>	<input type="checkbox"/>
Motrin (for headache or pain).....	<input type="checkbox"/>	<input type="checkbox"/>	<del>Sinus Medication and/or Antihistamines</del>	<input type="checkbox"/>	<input type="checkbox"/>
Benadryl (for insect bites, allergic)	<input type="checkbox"/>	<input type="checkbox"/>	Antacids (Turns, Pepto-Bismol).....	<input type="checkbox"/>	<input type="checkbox"/>
Cough Drops.....	<input type="checkbox"/>	<input type="checkbox"/>	Minor First Aid .....	<input type="checkbox"/>	<input type="checkbox"/>

**Please list if your child has had any of the following:**

**ALLERGIES** to Medications \_\_\_\_\_  
 Environmental (bees, etc) \_\_\_\_\_  
 Food (peanuts, etc) \_\_\_\_\_

**ASTHMA** \_\_\_\_\_ **INHALER NAME** \_\_\_\_\_

**DIABETES** \_\_\_\_\_ **TYPE** \_\_\_\_\_ **Rx** \_\_\_\_\_

**EPILEPSY** \_\_\_\_\_ **TYPE** \_\_\_\_\_ **Rx** \_\_\_\_\_

**HEART CONDITIONS** \_\_\_\_\_ **Rx** \_\_\_\_\_

**FREQUENT HEADACHES** \_\_\_\_\_ **Rx** \_\_\_\_\_

**FREQUENT NOSEBLEEDS** \_\_\_\_\_ **Rx** \_\_\_\_\_

**KIDNEY PROBLEMS** \_\_\_\_\_ **Rx** \_\_\_\_\_

**HEMOPHILIA** \_\_\_\_\_ **RHEUMATIC DISEASES** \_\_\_\_\_ **Rx** \_\_\_\_\_

**WEARS CONTACT LENSES?** \_\_\_\_\_ **GLASSES?** \_\_\_\_\_

**IS YOUR CHILD ON ANY OTHER MEDICATIONS?** \_\_\_\_\_ **If YES, please list**

**IS PARENT SENDING ANY MEDICATION WITH STUDENT WHEN TRAVELING?**

(Requires Additional County Form MIS 5183, "Administration of Medication in the School Permission Form")  
 Medication supplied by the parent **must** be in the original prescription container clearly labeled with the students name, the medication name, dosage, and time to be given. If any medications are listed, parent or guardian **must** speak with the designated employee **prior** to the activity.

*If during the school year, the student has any contagious disease, serious illness or accident, or if any of the above information changes, please notify the nurse traveling with the band.*

**PARENT'S AUTHORIZATION:**

I certify that the above history is correct as far as I know. I further certify that in the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by the Nurse or Band Director to perform such treatment as he may deem necessary to preserve the health of my child.

TYPED or PRINTED NAME

SIGNATURE

DATE

*Turn Completed Forms Into Band Director's Office in Forms Box*