FORT WALTON BEACH HIGH SCHOOL BAND
MEDICAL RELEASE/INFORMATION FORM School Year 2019 – 2020

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 ____________________________________Relationship to Child____________________

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)…..	☐	☐	**Dramamine** (for motion sickness)……….	☐	☐
Motrin (for headache or pain)…..	☐	☐	**Sinus Medication and/or Antihistamines**	☐	☐
Benadryl (for insect bites, allergic)	☐	☐	**Antacids** (Turns, Pepto-Bismol)…………	☐	☐
Cough Drops……………………	☐	☐	Minor **First Aid …………………………**	☐	☐

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