2020-2021 Veterans High School Band Permission and Medical Form

Please PRINT the following information.

Student's Last Name *Student's First Name* *School*

Name of Parent(s) *Student's Date of Birth*

Address *(Street)* *(City, State Zip)*

Phone #'s (Home) *(Work)* *(Cell)* *(Other)*

Permission Statement

I understand that Veterans High School Band students are going to participate in practices, performances and contests for the 2020-2021 school year sponsored by the Houston County Board of Education and Veterans High School. I hereby give permission for _____ to participate in this activity.

Medical Release Form

Should my child need immediate medical attention, the teacher(s) or chaperone(s) have my permission to seek immediate medical treatment.

Parent's Signature *Date*

Name of Insurance Company *Policy #*

Group # *SS# (Usually Required by Hospital for Treatment)*

If I cannot be reached in the case of an emergency, please call:

Name *Relation ship*

Phone #'s (Home) *(Work)* *(Cell)* *(Other)*

Is your child allergic to any medication(s)? *(circle one)* **Yes** **No**
Does your child have any other allergies we should be aware of? *(circle one)* **Yes** **No**
If answer is yes to any question above, please list the medication(s) and/or items your child is allergic to:

Does your child require any emergency medication(s)? *(circle all that apply)* **Epi-Pen** **Inhaler** **Glucagon** **Diastat**

Will your child take any daily/prescribed medication(s) while on the trip? *(circle one)* **Yes** **No**
If answer is yes, please list medication(s) your child will need to take and any necessary instructions:

I give the teacher(s) or chaperone(s) permission to give my child the following over-the-counter medication(s) if necessary. Medications will be administered based on the instructions printed on the bottle:

(circle one)

Acetaminophen (headache/fever)	**Yes**	**No**	(Dose:)
Ibuprofen (headache/anti-inflammatory)	**Yes**	**No**	(Dose:)
Benadryl (bee sting or allergy)	**Yes**	**No**	(Dose:)
Dramamine (motion sickness)	**Yes**	**No**	(Dose:)
Children's Pepto Bismol (stomach/diarrhea)	**Yes**	**No**	(Dose:)

Please list any additional medical information we should know about your child *(continue on back if needed)*