

**Lake-Lehman Band Medical Permission Slip School 2006-2007**

Dear Band Parent,

Completion of this form is necessary for us to be able to secure prompt medical treatment for your child should the need arise. All information on this form will be kept confidential.

I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_, who is participating in marching band, indoor jazz, percussion, color guard or other competition unit or field trip of Lake-Lehman Band, do give permission for the chaperones and authorized personnel on any trip to act "in Loco Parentis", in order to secure emergency treatment for illness or injury to my child, should this be necessary. Furthermore, I give my permission to the attending chaperone to administer the medications, which I have checked below to my child if necessary:

- |                                      |  |                                   |   |
|--------------------------------------|--|-----------------------------------|---|
| <input type="checkbox"/> Motrin *    | <input type="checkbox"/> Tylenol *   | <input type="checkbox"/> Aleve *  | <input type="checkbox"/> Tylenol with Codeine * |
| <input type="checkbox"/> Sudafed *   | <input type="checkbox"/> Benadryl *  | <input type="checkbox"/> Zyrtec * | <input type="checkbox"/> Claritin *             |
| <input type="checkbox"/> Cough Drops | <input type="checkbox"/> Non addicting cold/cough medicine (*) or equivalent brand |                                   |   |

\*\*\*If my child is taking prescription medications, I will notify the chaperone in charge prior to departure from the school so that the medication will be administered at the appropriate times. If your child is using an inhaler, please write down the name of the inhaler, the dose and frequency of use, and notify the chaperone in charge of same.

**HEALTH HISTORY:**

Allergies: \_\_\_\_\_, Date of last tetanus shot: \_\_\_\_\_  
List any other existing medical conditions and usual treatment:

\_\_\_\_\_

\_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_  
Policy or agreement #: \_\_\_\_\_

If your child is not covered by any insurance plan, the school regulations state that you must purchase the 24-hour Health Plan offered by the school.

**EMERGENCY CONTACTS:** List names of 2 individuals who may be contacted for emergencies.

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph: \_\_\_\_\_  
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph: \_\_\_\_\_  
Name of Family Physician \_\_\_\_\_ Ph: \_\_\_\_\_

**Parent Authorization**

I attest that the information in this document is correct to the best of my knowledge and that the student herein described has my permission to engage in all activities unless otherwise noted by me. I give my permission to the physician and hospital selected by the chaperone to hospitalize and/or secure the proper treatment for my child. I understand that this authorization will be used only in the event that the chaperone is unable to contact any of the above listed emergency numbers.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parents Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_