Pickens High School 2011 Medical and Travel Consent Form 2011-2012

STUDENT NAME:______________________________

STUDENT CELL:________________ PARENT CELL: (m)____________(d)______________

HOME PHONE: ________________ DATE OF BIRTH:______________________________

In the event of an emergency while my son/daughter is involved in a school band trip, I grant permission to the school, Mr. Oubre, or the chaperones to take whatever action necessary to obtain emergency care or treatment if deemed necessary. In the event that I cannot be reached, I hereby authorize the above named to give consent for my son/daughter, ___________________, to receive medical treatment.
Student Address ____
Student Date of Birth __________________ S.S. # ____________________________________
Mother's Name ________________________________ Mother's Work # ____________________
Father's Name ________________________________ Father's Work # ____________________
Student E-mail Address (write clearly!)____
Health Insurance Company ____
Insured's Name ____
Policy/Member ID Number ____________________ Group Name or Number __________________
Person(s) to be notified other than parent or guardian in an emergency:
Name/Phone ___________________________ Name/Phone ______________________________

******Students should carry health insurance of some kind. If a family or employer insurance is not available, the student should carry 24 hour school insurance. Students without insurance must provide a signed waiver letter from the parents.***

MEDICAL INFORMATION
In the event of an emergency, your child's welfare depends on explanation of any medical problems. Please be specific. Circle yes or no. Explain yes answers below.

Heart condition or disease	YES	NO	Diabetes	YES	NO	Insulin? _________
Convulsions/Seizures	YES	NO	Bone/Joint problems	YES	NO	
Nervous Conditions	YES	NO	Food/environmental allergies/intolerance	YES	NO	
Physician-requested activity restrictions	YES	NO	Medication allergy	YES	NO	
Headaches/migraines	YES	NO	Stomach disorders	YES	NO	
Fainting spells	YES	NO	Cold/Heat intolerance	YES	NO	
Sleep disorders	YES	NO	Seasonal allergies	YES	NO	
Contacts	YES	NO	Glasses	YES	NO	
Dental Appliance	YES	NO				

A. Has your child, or anyone in your immediate family, had a life threatening reaction to an insect sting?
YES NO
Please give date and brief description ____

B. Does your child have asthma requiring oral medications or inhalers? **YES NO**

C. Has your child ever had a life threatening allergic reaction to over the counter or prescription medications?
YES NO

NOTE If you answered YES to questions A. B. or C., you MUST SPEAK DIRECTLY with the chaperone chairperson before band camp (before pre-band camp for upcoming freshmen) to insure that the proper emergency kits and/or treatment is available.
Student's primary care physician ___________________________________
Hospital preference* ____
(*If applicable & if possible. Life threatening illnesses/injuries will be treated at the nearest emergency center)

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Additional information that may be helpful: ____

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LIST ALL MAINTENANCE MEDICATIONS PRESENTLY TAKING, GIVING GENERAL INSTRUCTIONS AND MEDICAL CONDITION BEING TREATED

____

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For overnight trips, you must provide the chaperone chairperson with a signed note detailing the name of medication not listed above, dosage, and any storage requirements. The chairperson will be available to store the medication, and dispense to your student, at your request. (Note: any narcotic-containing medication must be stored in the medical bag and dispensed by the chairperson or other designated adult.)

While away on trips, I give permission for a designated chaperone to dispense to my child any of the below over-the-counter drugs for MINOR problems. These medications will be administered only at your child's request. Individual drug administration instructions will be followed, and if this does not take care of your child's problem, further medical attention will be provided. Please initial yes or no, indicating your permission to administer the following medications. If you have any questions, please talk with your doctor or pharmacist before initialing.

	YES	NO		YES	NO		YES	NO
PAIN MEDICATIONS FOR HEADACHE, GENERAL DISCOMFORT, FEVER, MENSTRUAL CRAMPS:								
Advil tablets	____	____	Aspirin tabs	____	____			
Tylenol tabs	____	____	Aleve tabs	____	____			
INDIGESTION:			UPSET STOMACH:			NAUSEA/VOMITING:		
Mylanta	____	____	Pepto Bismal	____	____	Emetrol	____	____
COLDS, RUNNY NOSES:			SORE MUSCLES			INSECT BITES:		
Benadryl	____	____	Icy hot	____	____	Benadryl	____	____

IF YOUR CHILD HAS MOTION/CAR SICKNESS, PLEASE ADVISE US OF THIS, AND PROVIDE US WITH YOUR DRUG OF CHOICE.

PLEASE REMEMBER THAT YOUR STUDENT WILL BE TRAVELING OFTEN TO BAND FUNCTIONS. THIS MEDICAL FORM WILL BE TAKEN TO ALL AWAY FUNCTIONS, AND IS OUR LINK TO PROVIDING SAFE AND EFFECTIVE CARE FOR YOUR CHILD. ANY CHANGES IN MEDICAL HISTORY OR NEW MEDICAL PROBLEMS MUST BE REPORTED TO BAND PERSONNEL.

I HEREBY AUTHORIZE MR. MICHAEL OUBRE AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS TO SEEK MEDICAL ATTENTION FOR THE STUDENT LISTED ABOVE. I ALSO GIVE MY PERMISSION FOR THIS STUDENT TO PARTICIPATE IN ALL SCHEDULED, APPROVED BAND TRIPS. I ALSO TESTIFY TO RECEIVING AND READING THE PHS BAND HANDBOOK AND AGREE TO ABIDE BY THE POLICIES OF THE PHS BAND.

Student Signature	Parent/Guardian Signature	Student Shirt Size
________________________	______________________________	______________
Date ____________________	Date __________________________	

Please call with any questions or concerns not listed on this form, or to provide additional medical information that you want documented regarding your student. Thank you!