WVHS BAND **MARCHING WARRIORS 2018-19** # MEDICAL INFORMATION FORM

Please complete this form as clearly and accurately as possible. This information is needed so that staff can be informed of special needs and medical conditions to ensure the health of each member. This information will be held in the strictest confidentiality.

Student Name _____

Date of Birth (MM/DD/YYYY) _____

Parent / Guardian's Name _____

Person to Contact in Case of Emergency _____

Address _____

Emergency Phone _____

City, State, ZIP _____

Are you a United States Citizen (Yes or No)? _____

If you are NOT a US citizen, what citizenship do you hold? _____

Family Physician _____

Home Phone _____

Physician Phone _____

Parent's Cell or Work Phone(s) _____

Insurance Company & Policy Holder _____

Parent's Cell or Work Phone(s) _____

Policy Number _____

MEDICATIONS
all prescribed and over the counter drugs that will travel with student

DOSAGE / FREQUENCY:

_____ _____

_____ _____

_____ _____

_____ _____

Date of last Tetanus shot: _____

Allergies/allergic reactions to medications: _____

Major surgery: _____

Acute or chronic medical conditions: _____

Physical conditions that may limit activity: _____

Special dietary needs: _____

I give permission for WVHS staff to administer the following over-the-counter (non-prescription) drugs as needed:
____Tylenol (or generic) ____Advil (or generic) ____Aspirin (or generic) ___Benadryl (or generic)
____ Pepto Bismol (or generic) ____Dramamine (or generic)

Others (please list)_____

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PARENTAL CONSENT FORM/RESPONSIBILITY CLAUSE/MEDICAL PERMIT

PLEASE FILL OUT COMPLETELY.

I hereby give permission for _____ to participate in the WVHS MARCHING WARRIORS. I understand that WVHS, its officials, and chaperones shall not be, nor later become, liable or responsible in any way in conjunction with services, for any death, injury, damage, delay or irregularity which may occur while participating in this activity.

In the event that my student needs to take a prescription or non-prescription medication while participating, I give my child permission to use this medication. ALL medications, prescription or non-prescription, must be carried in the original labeled container. Prescription medications must be listed on the medical consent permit unless prescribed by a medical professional during an emergency.

Also, in case of emergency, I hereby give my consent for a qualified physician to perform any medical or surgical procedures he/she deems necessary to the welfare of my child. It is also understood that the staff or chaperones and medical personnel will make every attempt to contact parents, guardians, or relatives listed above when taking any such actions. Further, this authorization permits said physician to hospitalize, secure appropriate consultation, order injections, anesthesia (local, general or both) or surgery for my child if such emergency conditions warrant.

In addition, if a licensed physician is asked to provide medical care, I authorize this physician to examine and treat my child for general medical problems of a non-emergency nature (colds, sore throat, vomiting, diarrhea, insect bites, heat exhaustion, etc.) that may arise while participating.

Signature: _____

Relationship to Student: _____

Date: _____