Medical Permission Form - Off Campus Band Activities

Parent/Guardian Authorizations:

In the event I cannot be reached in an emergency, I ______________________ hereby give permission to seek emergency services, to secure and administer treatment, including emergency transportation and hospitalization for ______________________.

Over-the-Counter (**OTC**) Medication Regulations

I give permission for my child to be given the Over-the-Counter medications listed below (or generic equivalent), if needed, while at Band. Doses to be administered as per package directions.
I have **crossed off** any medications I **do not** want my child to be given.

After Bite for Bug Bites
Aloe
Anbesol Jr.
Bacitracin Ointment
Contact Solution
Cough Drops
Diphenhydramine HCL Antihistamine
Dramamine (Less Drowsy Formula)
Extra Strength Antacid Tabs
Eyewash
Glucose Tablet for Diabetics
Hydrocortisone 1% Cream
Ibuprofen
Jr. Strength/Regular Strength Acetaminophen
Loperamide HCL Anti Diarrhea
Midol
Sunscreen
Tussin DM Cough Suppressant Expectorant

Allergies ____

With my signature I agree to the above Parent/Guardian authorizations

Student Name ________________________ Home Phone # ________________________

Parent Signature ________________________ Cell Phone # ________________________

Print Name ________________________ Date ________________________

The Music Department has a volunteer MA licensed nurse (at least one) that travels on all trips with the band.

Please remember if you child requires prescription medication we must adhere to the school policy. The medication must be in an original container with the prescription on it; please give the medication to the nurse before the trip.

Unfortunately if this form is not completed the nurse will not be able to give your child any medication. Thank You for your attention to this matter.

*If your child has any medical problems the nurses should be aware of, please address on back of this form.

This form will be valid for one year from the date of signature, please update us if there are any changes before then.

Thank You!

Student Name ___________________________

Date of Birth ___________________________

Permission is granted to allow ___________________________Child of ___________________________ to possess and use

(Please check appropriate box)

Asthma Inhaler Date ___________________________

Epinephrine Auto Injector Date ___________________________

Parent's Signature ___________________________

Please attach copy of Medical Order for use of Inhaler/Auto Injector Epinephrine

Asthma Inhaler and EPI Pen Permission Form

Licensed Medical Personnel must complete the following for use of the above

☐ Asthma Inhaler ☐ Epinephrine Auto Injector

1. Name of Medication ___________________________
2. Date of Medication Order ___________________________
3. Route and Dosage of Medication ___________________________
4. Frequency and Time of Medication Administration or Assistance
   ____
5. Diagnosis and Any Other Medical Conditions Requiring Medications
   ____
6. Any Special Side Effects, Contraindications and Adverse Reactions to be observed?
   ____

I hereby verify that ___________________________ has a valid prescription, and the knowledge and skills to safely possess and use the following at Band.

☐ Asthma Inhaler ☐ Epinephrine Auto Injector

Licensed Medical Personnel Signature ___________________________

Date ___________________________________ Print Name ___________________________

Business Phone ___________________________ Emergency Phone ___________________________

Please provide Epi-Pen if your child uses one for student to carry and one for nurse to carry.

If any of these criteria are not met, the Band will not be able to allow your child to carry or store his/her asthma inhaler or epi-pen. If you or your child's physician has any questions regarding this policy, please contact the Band Director/Band Nurse.

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Kelly Gillis/Nurse Cell Phone 508-847-6454 orcasymphony@comcast.net