

STUDENT NAME: \_\_\_\_\_

TEMPORARY MEDICAL GUARDIANSHIP

TO WHOM IT MAY CONCERN:

I (we) the undersigned, \_\_\_\_\_, are the natural parents or legal guardians of \_\_\_\_\_ (please print). During our absence he/she has been \_\_\_\_\_ (please print)

placed in the temporary care of **WAXAHACHIE HIGH SCHOOL BAND**, who is/are empowered by this statement to call for and authorize medical care and assistance in the event of injury, accident or illness involving our child or children. It is my (our) intention that this statement serve as authorization for such medical care to be administered during the following period of time:

Beginning Date **June 1, 2017** through the Ending Date **June 1, 2018.**

In the event that further medical consultation is required, the **physician** who has most recently examined the child/children is: \_\_\_\_\_ Phone: \_\_\_\_\_ Child DOB: \_\_\_\_\_

Known Allergies: Drugs: \_\_\_\_\_ Foods: \_\_\_\_\_ Last Tetanus: \_\_\_\_\_

List all medical conditions, history of surgeries, and serious injuries (use other side if needed): \_\_\_\_\_

List Names and Doses of all regular medications: \_\_\_\_\_

Insurance information (recommended) \_\_\_\_\_

In case of emergency, the following person/people is/are also authorized to give consent for treatment if the parent/legal guardian cannot be reached:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Legal Guardian [PRINT]: \_\_\_\_\_ Signature \_\_\_\_\_ (please print)

Emergency Contact Numbers for Parents (include Home, Work, and Cell phones): \_\_\_\_\_

DRUG POLICY

Students may **not** share any medications, nor receive **any other medications** from any other parent/student.

All **controlled** substances, such as narcotic pain medications, Ritalin, etc., **must** be collected by the directors/designated head chaperone with appropriate dosing instructions signed by the parent/legal guardian.

All medications must be in the original containers.

PRIVACY STATEMENT

For your information, please be advised that all information on this form will only be used to assist in obtaining emergency medical treatment.

*I have read and understand the above WHS Band policy on medication, as well as the above Privacy Statement.*

Parent/Legal Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Medication Disbursement Authorization

### Prescription and Over-the-Counter Medications

If your child is currently taking medication or you would like to authorize the disbursement of medication in case your child becomes sick, please complete this form. **This would include both over-the-counter medications as well as prescription medications.** All medications must be in their original container and listed on this form. If your child carries an inhaler then they need to keep the inhaler with them at all times. If you would like to send a second inhaler to be kept by the chaperones just in case your child loses one then you may do so. Please make sure ALL medications are clearly labeled and include the student's name on the packaging. Please send all medications together in a Ziploc bag prior to any travel event.

**Student's Name [Print]:** \_\_\_\_\_

\*\*\*Please **circle ALL** the medications that we are allowed to distribute to your child if needed:

- |  |                                   |                 |
|--|-----------------------------------|-----------------|
| Tylenol/Acetaminophen (2 tablets)                | Advil/Ibuprofen (1 tablet)        | Tums            |
| Imodium AD                                       | Pepto-Bismol                      | Cough Drops     |
| Benadryl/Antihistamine                           | Triple Antibiotic Ointment        | Anti-itch Cream |
| Icy Hot or ActivOn (Menthol & Methyl Salicylate) | Aspercreme (Trolamine salicylate) |                 |

**\*\*\*If it is NOT circled we will NOT give medication even if your student says they have had it before. It is difficult for us to call parents from football games and marching contests, so please circle ALL if you give your permission for us to give these items to your child. We only give if they need it, not just because they ask for it.\*\*\***

**List other medications or detailed instructions below:**

Medicine Name	Dosage	Times to be given	Special Instructions
Example: Delysm	2 tsps	Every 12 hours	As needed

I, \_\_\_\_\_, give my permission for a Waxahachie Band Adult Chaperone to administer the medications listed on this form to my child, \_\_\_\_\_, based upon the instructions provided.

Parent Contact Number(s): \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_