Band Medical Information Form: 2017-2018

Every effort will be made to see that your child is well taken care of. However, since we must be prepared for any situation, please complete the following information. Please complete both front and back sections of this form.

Student Name:_____ **Grade:**_____ **Date of Birth:**_____

Doctor Name:_____ Office Phone:_____

Preferred Hospital:_____

MEDICAL HISTORY
Bee/Wasp Allergy: **YES**____ **NO** ____

If yes, describe reaction and treatment:_____

Medication Allergies/Asthma:_____

Please describe **ALL CONDITIONS or CHANGES** to previous health status that would need special consideration: (include medical and dietary requirements)

_____

_____

_____

_____

_____

Do we have your permission to take your child to the nearest doctor or hospital should, in our opinion, the situation warrants this action? **Yes** ____ **No** _____
Medical information may be shared with school personnel, EMT's, and hospital personnel on a need-to-know basis. If it is necessary to transport your child, it will be the responsibility of the parent/guardian to pay for this service.

Please give the name and phone of parents/guardian, or nearest responsible person, who will be available for emergency contact:
Name:_____ Relationship:_____
Phone (home):_____ (work):_____ (cell)_____
Name:_____ Relationship:_____
Phone (home):_____ (work):_____ (cell)_____
Name:_____ Relationship:_____
Phone (home):_____ (work):_____ (cell)_____

It is you're responsibility to update this information if any changes occur during the school year, including emergency phone contact numbers.

18250 N. Union St., Westfield, IN 46074 Telephone: (317) 867-6800

Permission for Non-Prescription Medication (School Provided)

My child may receive the medication(s) checked below all medication are given according to the medication labels:

_____ Motion Sickness Medication
_____ Acetaminophen
_____ Ibuprofen
_____ Mylanta/Tums
_____ Benadryl
_____ Topical Preparations (Antibiotic Cream/Anti-itch Cream/Carmex/ Chap Lip medication/Sunscreen

Additional comments/ instructions:_____

_____

_____

I authorize the band nurse or school personnel trained by the school nurse to be my agent to give medication checked above to my child

Parent/Guardian Signature:_____ Date:_____

Permission for Non-Prescription and Prescription Medication (Parent Provided)

Name of Medication:_____ Dose:_____

Time to be given:_____

To be given for the period from (date)_____ to (date)_____

Name of Medication:_____ Dose:_____

Time to be given:_____

To be given for the period from (date)_____ to (date)_____

Name of Medication:_____ Dose:_____

Time to be given:_____

To be given for the period from (date)_____ to (date)_____

Parent/Guardian Signature:_____ Date:_____ It is you're responsibility to update this information if any changes occur during the school year, including emergency phone contact numbers.