Penn-Trafford Warrior Marching Band

Dear Band Parent/Guardian:

Please fill out both sides of this form completely. Please print clearly. This form is needed before any medications can be administered. **It must be completed and turned in before the start of Band Camp.** Any band member without this completed form will not be permitted to participate in band activities.

Note: Your signature on this form must be notarized.

MEDICAL HISTORY AND PERMISSION FOR TREATMENT

I, ____, grant permission to Mr. Thomas Monteleone, Band Director, or his designee to act as spokesperson in granting permission for emergency treatment or hospitalization, including anesthesia, for my child, ____, while traveling with the Penn-Trafford High School Marching Band.

> **NOTE:** Every effort will be made to contact the parent/guardian or nearest relative **before any treatment is given.** Only if that person cannot be contacted will permission be given to a physician to treat an injury or illness.

Over the Counter Medication

Chaperones and nurses are not permitted to give over the counter medications without written permission. If your child has frequent headaches, upset stomach, etc. and takes over the counter medications, we need to be aware of this. Please check any of the following medications to indicate your permission for them to be administered to your child by chaperones, nurses, or those in charge if it is deemed necessary.

_______ **Tylenol**

_______ **Advil**

_______ **Benedryl**

_______ **Imodium**

_______ **Dramamine**

_______ **Antacids**

_______ **Cough Drops**

_______ **Throat Drops**

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MEDICAL HISTORY

(Please print all information)

Student Name:____ Birth Date:______________
Parent/Guardian:____
Address:____

____

Phone: Home_________________Mother's Work___________________Father's Work___________________
Cell Phones ____

Do you now or have you had rheumatic fever, epilepsy, heart conditions, diabetes, migraines, etc.?___________
If yes, please specify:____
List all medications/dosage info for above conditions ____

____

Have you had surgery in the past year? _________________ If yes, please specify ________________________

____

Do you have asthma? __________ If yes, please list medications/inhalers ________________________________

____

Are you allergic to bee stings? ________________ If yes, please list reactions/medications ________________

____

List any other allergies to medications, food, etc. and type of reactions _____________________________________

____

List any other current medical conditions and medications you are taking at this time _____________________

____

Date of last tetanus shot: ____________________

Family Doctor:____ Phone:________________

Health Insurance Co:____ Phone:________________
Address:____ ID# __________________
____ Policy# _______________
Name of Guarantor for Insurance:____
Name of Employer:____
Please list any special instructions for your coverage (e.g. must be coordinated through PCP, etc.) ____________

____

Please attach a copy of both sides of the band member's medical insurance cards.

Nearest relative to contact in case of emergency:
Relationship:____ Home Phone:_______________________________
Work Phone:____ Cell Phone:_________________________________

I attest that this information is complete and accurate to the best of my knowledge and give my permission for emergency treatment and administration of over the counter medications indicated. I understand that in the final disposition of an emergency case, the judgment of the school authorities prevails.

Signature:________________________________ Date:___________

Affix Notary Seal Here

Notary Signature:__________________________ Date:___________

Date Notary Term Expires:___________________________________

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