

2011 - 2012 Complete THS Medical Forms
Rio Grande Emergency Medical Release Authorization
Emergency Medical Release Authorization
University of Rio Grande Band Camp

The purpose of this form is to make it possible to obtain emergency medical treatment for any student in the event that it may become necessary while at band camp.

Name of Student	Date of Birth	
Parent/Legal Guardian	Address	Phone

I certify that the above medical information is true to the best of my knowledge and I give consent for the administration of medicines and treatment procedures as recommended by the medical personnel of the University of Rio Grande. Consent is also granted to a licensed physician, surgeon, or dentist for necessary treatment when indicated.

Please provide the following information:

Allergies _____

Medications being taken _____

Date of last tetanus immunization _____

Physical impairments (heart, epilepsy, etc.) or chronic illness _____

Previous Surgery _____

Previous hospitalization _____

Other pertinent information to which a physician should be alerted _____

Family Physician _____ Phone _____

Employer of person carrying insurance _____

Insured (father, mother, etc) _____ Phone _____

Medical Insurance Company _____ Policy # _____

Name, phone and relation to student of alternate contact in case parents cannot be reached at home or work _____

Date _____ Signature of Parents or Guardian _____

2011 - 2012 Complete THS Medical Forms
Tippecanoe High School Music Department
Health Information **(GREEN)**
To be completed by the parent or guardian

STUDENT INFORMATION

Name		Age:
Address		Birth date:
Phone #		Grade for 2011-2012 year: 9 ___ 10 ___ 11 ___ 12 ___

PARENT INFORMATION

	Mother	Father
Name		
Address	___ Same as student	___ Same as student
Phone #s	Home Work Cell	Home Work Cell

THIRD PARTY CONTACT

Name	Relationship
Address	
Phone	

Please check any of the following that apply to your child:

Asthma ___ Seizures ___ Hay fever ___ Sleepwalking ___ Headaches ___ Food allergies ___ Medicinal allergies ___ Seasonal allergies ___ Fainting ___ Contact lenses ___ Diabetes ___ Hypoglycemia ___ Sun sensitivity ___
Date of student's last tetanus booster:
Any other health concerns you would like the staff to be aware of:

CONSENT FOR TREATMENT

Refusal to Consent	
I do NOT give my consent for emergency medical treatment of my child.	
Parent Signature _____	Date _____
To Grant Consent:	
I hereby give consent for the following medical providers and local hospital to be called:	
Physician _____	Phone _____
Dentist _____	Phone _____
Local Hospital _____	Phone _____
Parent Signature _____	Date _____
YOU MUST ATTACH A XEROX COPY OF BOTH SIDES OF YOUR INSURANCE CARD TO THIS FORM	

2011 - 2012 Complete THS Medical Forms
Parent Permission for Administration of OVER THE COUNTER
Medication for Band Events, School Year 2011 - 2012 (GREEN)

Name of Student _____

*We (I), the undersigned who are the parent(s)_____, foster parent(s)_____, guardian(s)_____ (checkmark the applicable category) of the above named student give our permission for the administration by a member of the school staff of the **OVER THE COUNTER (NON-PHYSICIAN PRESCRIBED) MEDICATIONS** indicated below during any band event, on or off campus.*

We (I) agree to hold the school district and its employees free from any and all responsibility for the results of such Over-the-Counter medication or the manner in which it is administered, and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

It is the parent's responsibility to indicate any ALLERGIES to medications that the student may have.

ALLERGIES: _____ **None** _____

Please indicate approval/non-approval below for administration of the listed medications by placing a check mark in the appropriate column.

Dosage will be administered via package directions unless specified otherwise by physician's orders (must have yellow sheet on file). Generic equivalents may be substituted for brand names.

Approve	Disapprove	<u>Ailment</u>	<u>Treatment Available</u>
		Headache, menstrual cramps, general minor pain	Acetaminophen (Tylenol), Ibuprofen (Advil/Motrin), Midol or generic equivalent
		Cuts and scrapes	Antibiotic ointment, First Aid cream
		Cough/ sore throat	Cough drops, lozenges
		Upset stomach	Antacid tablets
		Skin rash/ sunburn	Callergy Clear, Benadryl, medicated powder, cornstarch, hydrocortisone cream, aloe, topical sunburn spray
		Allergic reaction	Benadryl (oral) – parent will be notified
		Irritated eyes	Visine, saline eye drops, allergy eye drops
		Sprains / strains	Ice
		Insect sting/bite	Callergy Clear

I hereby give permission for school personnel to use the above indicated non-prescribed medications and/or treatments for my son/daughter _____ (student name) while at any on or off campus band event.

Parent Signature _____ Date _____

Parent Address _____

Parent Phone # _____

2011 - 2012 Complete THS Medical Forms

PARENT SIDE (YELLOW)

Parent Release for Administration of Medication at SCHOOL

To (Principal) _____ (School) _____

Student Name _____ (Grade) _____

We (I), the undersigned who are the parent(s) _____, foster parent(s) _____, guardian(s) _____
(checkmark the applicable category) of _____ (Student's name)
request indicated medication be administered to our child in accordance with the instruction of
our physician Dr. _____ as noted in the instructions on the other side
of this form.

We (I) understand that the administration of said medication is to be done under the supervision
of a member of the school staff.

**The medication(s) must be received in the original container in which it was either
dispensed by the prescribing physician or licensed pharmacist, or purchased from the
store.**

Furthermore, we (I) understand that the school personnel are not legally obligated to administer
medication to any child and therefore, we (I) agree to hold the school district and its employees
free from any and all responsibility for the results of such medication or the manner in which it is
administered, and to indemnify each of them against loss by reason of any civil judgment arising
out of these arrangements which may be rendered against them.

Furthermore, we (I) will notify the school immediately if we (I) change physicians or medication,
or terminate the use of this medication for any reason.

We (I) agree to submit a revised statement signed by the physician who prescribed the
medication to school personnel if any of the information provided by the physician on the other
side of this form changes.

Signature of Parent/Guardian _____ Date _____

Address of Parent/Guardian _____

Home Phone # _____ Business Phone # _____

2011 - 2012 Complete THS Medical Forms

PHYSICIAN SIDE (YELLOW)

Physician Request for Administration of Medication at SCHOOL

To _____ School

Name of Student _____

Address of Student _____

ALLERGIES _____ None _____

Since the medication for this student cannot be scheduled for other than school hours, and the administration of such medication(s) may be supervised by medically untrained personnel, it is requested that the medication as listed below be administered by school personnel.

MEDICATION(S)

Name of Medication	Dosage	Time to give	Route / method	Date to begin	Date to end	Possible reactions / Special instructions
Reason for medication						

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Reason for medication						

Please write clearly. All areas above must be filled in completely.

If MEDICATION IS AN ASTHMA INHALER, please complete the following

- **MUST** the student **carry** and **self administer** the asthma inhaler? **Yes**____ **No**____
- Procedure to follow in the event that the medication does not produce the expected relief from the student's asthma attack _____
- Adverse reactions for unauthorized user of asthma inhaler _____

Physician's Signature _____

Physician's Address _____

Physician's Phone # _____ Date of this request _____