

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.

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.

Insurance Information (Required)

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.) _____

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.

_____ Acetaminophen (Tylenol)	_____ Ibuprofen (Advil/Motrin)
_____ Benadryl	_____ Antacids
_____ Cough drops	_____ Throat Lozenges

MEDICAL HISTORY

(Please print all information)

Student Name: _____ Birth Date: _____

Parent/Guardian: _____

Address: _____

Phone: Home _____ Mother's Work _____ Father's Work _____

Cell Phones _____

Date of last tetanus shot: _____

Family Doctor: _____ Phone: _____

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 _____

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.

Parent/Guardian Signature _____ Date _____

Please note: It is the responsibility of the parent/guardian to notify the head band nurse of any changes to the above information. Notification of changes must be made in writing.