

STUDENT NAME: _____

TEMPORARY MEDICAL GUARDIANSHIP**TO WHOM IT MAY CONCERN:**I (we) the undersigned, _____, are the natural parents or legal
(please print)guardians of _____ . 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 7, 2010** through the Ending Date **June 7, 2011.**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: _____

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

- | | | |
|-----------------------|-----------------|---------------------|
| Tylenol/Acetaminophen | Advil/Ibuprofen | Aleve |
| Imodium AD | Pepto-Bismol | Zantac |
| Tums | Cough Medicine | Dramamine or Bonine |
| Benadryl | Zyrtec | Claritin |

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: _____