MEDICAL RELEASE FORM
MUNFORD HIGH SCHOOL BAND 2017-2018

Student Name (one form per student):_____

Address: _____

City: _____**State:** _____**Zip:** _____

Home Telephone: _____**DOB:** _____ **Grade:** _____**Sex:** _____

Students SSN: _____

*****Only to be used in the event that higher level of medical treatment is required*****

Medical History (check all that apply):

☐ Diabetes ☐ Epilepsy ☐ Asthma (NOT Prescribed Inhaler) ☐ Asthma **(Currently Prescribed Inhaler)**

**** Students must present prescribed inhalers to an authorized chaperone at every event/ trip or he/she will not be allowed to travel/participate. No exceptions will be made. ****

☐ Allergies (i.e. food, medicine, etc.): _____

Other medical problems: _____

***** If more space is needed for other medical problems please attach another sheet with your child's name on it or use the back of this sheet. All medical forms are on a need to know basis and will be kept in the strictest of confidence. *****

Please mark any of the over-the-counter medications the student may take. Students are not allowed to carry medication of any kind. Medications are only administered by an authorized chaperone.

☐ Tylenol	☐ Cortaid Cream	☐ Cough Syrup/Drops
☐ Ibuprophen	☐ Pepto Bismol	☐ Throat Lozenges
☐ Midol	☐ Benadryl	☐ Tums
☐ Neosporin	☐ Betadine (to clean cuts)	☐ Eye Drops
☐ Activated Charcoal (food poisoning)		☐ Scopolamine Patch (motion sickness)

Please provide a list of all prescription medications currently being taken: _____

_____

_____

I, _____, (print name of parent/guardian) give permission for Mr. Barry Trobaugh, Director of Bands, or any adult named by Mr. Trobaugh to act in my behalf to approve appropriate medical treatment for my son/daughter _____ should any emergency medical treatment be necessary and will make any necessary financial reimbursements. I further state that I am of lawful age and legally competent to sign this Medical Release; that I understand that the terms herein are contractual and are not a mere recital; and that I have signed this document as my own free act. I agree to release and hold Mr. Trobaugh harmless or his nominee from any liability for decisions made pursuant to their authorization. I have fully informed myself of the contents of this Medical Release by reading it and that the medical and insurance information I give below is accurate.

Name of Insurance Company_____

Account Number_____

Doctor's Name_____ Phone _____

Signature of Parent/Guardian_____

Work Phones _____Cell Phones _____

Emergency Contact (Name/Phone Number) _____

Relationship to Child _____