Chaperone:_____

Albemarle High School Band
Permission for Emergency Care & Student Health Form

Student Name:_____Date of Birth:_____Grade: _____Sex: M or F

Parent/Guardian Name(s):_____Soc. Security # (optional):_____

Address:_____

Home Phone:_____Emergency Contact:_____Phone:_____

Business Phone(M):_____(F):_____Cell Phone(M):_____(F):_____

Did student purchase school insurance? Y N Regular?___24-Hour?____Athletic?____

Insurance Company under which student is covered:_____Phone:_____

Name of Insured:_____Policy #:_____Group #:_____

Does your insurance require precertification? Y N Phone # for precertification if different from above:_____

Name of student's physician:_____Phone:_____

Is the student allergic to any medications? If so, please list:_____

Is the student under physician's care for health needs on a continuing basis? Y N

Is the student under medication or treatment on a continuing basis? Y N

If yes to either of above two questions please explain and list all medications currently being taken:_____
_____
_____
_____

Date of last tetanus shot:_____Food allergies:_____

Does the student require a special diet or prefer vegetarian?_____

I GIVE THE CHAPERONES PERMISSION TO ADMINISTER THE FOLLOWING *OVER THE COUNTER* MEDICATIONS IF NECESSARY:

Advil:_____Tylenol:_____Benadryl:_____Imodium:_____Sinus/Cold meds:_____Pepto Bismol:_____
Imitrol:_____Bonine (for motion sickness):_____
Other (please list):_____
Please give permission for all medications which are not problematical to your child; otherwise we can't administer any medications that haven't been checked on this form without contacting you.

I GIVE THE CHAPERONES MY PERMISSION TO CALL MY CHILD'S PHYSICIAN OR ANOTHER PHYSICIAN IN AN EMERGENCY WHEN MY CHILD'S PHYSICIAN OR I CANNOT BE CONTACTED.

THEY ALSO HAVE MY PERMISSION, IN AN EMERGENCY WHEN I (OR MY CHILD'S PHYSICIAN) CANNOT BE CONTACTED, TO TAKE MY CHILD TO THE EMERGENCY ROOM OF THE NEAREST HOSPITAL, AND THE HOSPITAL AND ITS MEDICAL STAFF HAVE MY AUTHORIZATION TO PROVIDE TREATMENT THAT A PHYSICIAN DEEMS NECESSARY FOR THE WELL-BEING OF MY CHILD.

Signature of Parent_____Date_____