

Charlotte High School Silver King Band
Medical Form

Student's Name: _____
(Last) (First) (Middle)

Student's Address: _____
(No.) (Street) (City) (State) (Zip)

Student's Date of Birth: _____ Student's Social Security # _____

Father's Name: _____ Father's Home Phone: _____

Father's Address: _____

Father's Cell: _____ Father's Work# _____

Mother's Name: _____ Mother's Home Phone: _____

Mother's Address: _____

Mother's Cell: _____ Mother's Work#: _____

Student's Physician: _____ Phone #: _____

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Health Insurance

Company: _____
(Copy of Insurance Card Attached)

Group #: _____ ID/Subscriber #: _____

Social Security Number of Cardholder _____

Type of Insurance: Private _____ Group: _____ No Medical Insurance at this time _____

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Person To Notify In Case Of An Emergency And You Cannot Be Reached

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Health History

Student's Name: _____

Drug Allergy (List) _____

Food Allergy (List) _____

Insect Bite Allergy (Life Threatening) _____

Epi Pen Required for Allergy _____

Medical Problem(s)

ADHD: _____ Last Tetanus Shot: _____

Current Medications, Amount and Dosage:

Medications/Parental Permissions for Over-the-Counter Medications
Provided by the

I give my permission for the nurse employed by the school system or other authorized school personnel to assist my child with the self-administration of each of the following medications that I have initialed:

(Parent/Guardian Signature)

MEDICATION

- Tylenol
- Ibuprofen
- Benadryl
- Desitan/ Baby Oil for dry skin
- Tums
- Mylanta
- Calamine Lotion/Band-Aid
- Immodium AD

- Artificial Tears or Bausch & Lomb Eye Wash
- Cough Drops
- Cepacol Spray or Lozenges
- Anbesol Ointment / Orajel
- Mineral Ice
- Antibacterial Ointment (Neosporin)
- Vaseline Aloe Vera / Aloe Gel/Sunscreen
- Sudafed*

Permission for Accompanying Physician

I give my permission for any physician who is accompanying the Band on the trip to provide medical treatment to my child if needed.

(Parent/Guardian Signature)

Permission for Emergency Medical Treatment

In the event of an emergency and I am (or other emergency contact is) unable to be reached, I give permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic. **We will invoke this authorization only as a last resort when all possible alternatives have been exhausted.**

I HAVE READ AND UNDERSTAND THIS PERMISSION FORM AND UNDERSTAND THAT THE DISTRICT SCHOOL BOARD OF CHARLOTTE COUNTY AND THEIR REPRESENTATIVES ON THIS TRIP ARE RELEASED FROM LIABILITY AS A RESULT OF ANY INJURY OR DAMAGES FROM MY CHILD'S PARTICIPATION IN THE FIELD TRIP ACTIVITY.

(Parent or Guardian Signature)

(Date)

Sworn to and subscribed before me this _____ day
of _____ (year) _____

By: _____ who is personally known to me or who
produced _____ as identification.

Notary Public _____

My commission expires: _____