FORT WALTON BEACH HIGH SCHOOL BAND
MEDICAL RELEASE/INFORMATION FORM School Year 20____ - 20____

Parent or Guardian's authorization for students traveling with the Fort Walton Beach High School Band. This authorization is good for a period of one (1) year from date of signing.

Student Name _____ Sex _____ Age _____ Grade _____
Birthday _____ Home Phone _____ Cell Phone _____
Address _____
Mother's Name _____ Business Phone _____ Cell Phone _____
Father's Name _____ Business Phone _____ Cell Phone _____
Health Insurance Company _____ Policy # _____
Family Physician _____ Phone _____

Please list an emergency contact person in the event that you are unavailable.
Name _____ Relationship to Child _____
Home Phone _____ Work Phone _____ Cell Phone _____

Date of Last Tetanus Shot _____

May the Band Director or Nurse in charge give your child the following?
If left blank, medications cannot be given without parental consent.

	YES	NO
Tylenol (for headache or pain)		
Motrin (for headache or pain)		
Benadryl (for insect bites, allergic		
Cough Drops		

	YES	NO
Dramamine (for motion sickness)		
Sinus Medication and/or Antihistamines		
Antacids (Tums, Pepto-Bismol)		
Minor First Aid		

Please list if your child has had any of the following:
ALLERGIES to Medications _____
Environmental (bees, etc) _____
Food (peanuts, etc) _____
ASTHMA _____ **INHALER NAME** _____
DIABETES _____ **TYPE** _____ **Rx**_____
EPILEPSY _____ **TYPE** _____ **Rx** _____
HEART CONDITIONS _____ **Rx** _____
FREQUENT HEADACHES _____**Rx** _____
FREQUENT NOSEBLEEDS _____ **Rx** _____
KIDNEY PROBLEMS _____ **Rx** _____
HEMOPHILIA _____ **RHEUMATIC DISEASES** _____**Rx** _____
WEARS CONTACT LENSES _____ **GLASSES** _____

IS YOUR CHILD ON ANY OTHER MEDICATIONS? _____ **If YES, please list** _____
_____

IS PARENT SENDING ANY MEDICATION WITH STUDENT WHEN TRAVELING? _____
(Requires Additional County Form MIS 5183, "*Administration of Medication in the School Permission Form*")

Medication supplied by the parent **must** be in the original prescription container clearly labeled with the students name, the medication name, dosage, and time to be given. If any medications are listed, parent or guardian **must** speak with the designated employee **prior** to the activity.

If during the school year, the student has any contagious disease, serious illness or accident, or if any of the above information changes, please notify the nurse traveling with the band.

PARENT'S AUTHORIZATION:

I certify that the above history is correct as far as I know. I further certify that in the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by the Nurse or Band Director to perform such treatment as he may deem necessary to preserve the health of my child.

_____ _____ _____
TYPED or PRINTED NAME SIGNATURE DATE