

BAILEY MIDDLE SCHOOL BANDS
11900 BAILEY ROAD
CORNELIUS, NC 28031
980-343-1068

Please print in black or blue ink.

Medical Information and Consent Form

Student Information

Name _____ DOB _____
Last First MI MM/DD/YYYY

Address _____

City _____ State _____ Zip _____

Parent/Guardian Information

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other _____

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Cell Phone _____ Other _____

Doctor Information

Doctor _____ Phone _____

Medical Information

To be completed by Parent/Guardian (Please sign where the full signature is required.)

I hereby give permission to administer minor medical treatment to my child _____ including giving over-the-counter medications.

Please initial beside each medication your child is allowed to have:

___ **ALL**

___ **NONE**

___ Benadryl

___ Dramamine (Motion Sickness)

___ Immodium

___ Tylenol (Acetaminophen)

___ Advil (Ibuprofen)

___ Aspirin

___ Pepto-Bismol

___ TUMS

___ Sudaphedrine (Sudafed)

___ Other OTC medications not listed _____

Date of Last Tetanus Toxoid _____

Signature of Parent/Guardian _____ **Date** _____

- **Please list all medications your child takes. Include regular medications as well as medication carried in the event of an emergency (i.e. EpiPen, asthma inhaler).**

- **Please list any and all allergies your child has (include food, medicine, insect stings, etc.).**

- **Please list any medical conditions or recent surgical procedures that your child may have or have had that would be pertinent to the health and welfare of your child while with the band.**

In the event I cannot be reached in an emergency, I hereby give my permission for the Bailey Band Staff and/or Volunteer Medical First-Aid/Chaperones to dispense the above listed prescribed medications, which I have properly provided in their original prescribed containers and/or secure proper medical treatment for my child as named above. Hospital medical staff is authorized to make examinations and to render any medical and/or surgical treatment deemed necessary for my child's health and welfare. I also authorize release of medical information to the proper insurance company for payment purposes.

Signature of Parent/Guardian _____ **Date** _____

Insurance Information

PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD.

Insurance Company Name _____

Policy # _____ Carrier SS# _____

Name of Adult Carrier _____

Signature _____ **Date** _____

Privacy Notice to Parents

In order to properly care for your child, selected medical information will be available to chaperones. This form will be placed in a binder and secured by Ms. Petersen. Minimal information will be made available to Chaperones for the trip. All other information will be kept confidential and will be divulged only on a need-to-know basis.

I have read and understand the Privacy Notice:

Signature of Parent/Guardian _____ **Date** _____