## Royal Oak High School Bands & Orchestras

## Medical Information and Medical Release Form

Student's Name _____
Last Name First Name Middle Name

Home Address _____

City _____ State _____ Zip _____

Home Telephone Number _____ Cell Number _____
Include Area Code Include Area Code

Student's Date of Birth _____
Month/Date/Year

**Known medical conditions**:

*Check any known conditions. Use blank boxes to add medical conditions not listed.*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Asthma | | Hypoglycemia | | Lactose intolerant | | |
| | Diabetes | | Sun sensitivity | | Gluten sensitivity | | |
| | Seasonal Allergies | | Migraines | | Latex allergy | | |
| | Nut Allergy | | GERD | | Hay fever | | |
| | Fainting spells | | Motion sickness | | Digestive problems | | |

**Medications** student will be taking while on trip (include dosage frequency):

_____
_____
_____
_____
_____

*Note: Please bring all medication(s) in original container(s). Student will be responsible for administering his/her own medication(s). Please note above if your student carries an inhaler or epipen.*

**Insurance Information**

Name of Primary Insured _____ Date of birth _____

Primary Insured's Employer _____

Insurance Provider _____

Group Number _____ Policy/Member Number _____

***Please copy insurance card and attach to this form.*

**Over-the-Counter Drugs** that chaperones may give to student if requested:

*Please initial any drug(s) that you consent for a chaperone to administer to your student if needed.*

____ Tylenol (acetaminophen)

____ Motrin (ibuprofen)

____ Dramamine

____ Neosporin/Polysporin (with bandaid)

**Consent to Receive Treatment**

As the parent/guardian of _____,
Name of student

I authorize treatment of the above mentioned student by a qualified physician or nurse in the event the student requires medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual, trained in first aid, if in the opinion of that individual, delay might endanger the student's life, cause disfigurement, or cause undue harm. On this Medical Information Form I have listed any allergies, ongoing medical treatment, or medical problems which might influence treatment of this student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the understanding that except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

Parent/Guardian Signature _____ Date _____

**Emergency Contact Information**

Emergency Contact #1 Name _____

Relation to Student _____

Cell phone # _____ Home phone number _____

Work phone # _____

Emergency Contact #2 Name _____

Relation to Student _____

Cell phone # _____ Home phone number _____

Work phone # _____