

**JAMES LOGAN HIGH SCHOOL
2007-2008 BAND & COLORGUARD**

MEDICATION RELEASE AUTHORIZATION FORM

STUDENT NAME: _____
(PLEASE PRINT CLEARLY) Last Name First Name

Grade: ____ **Student ID#** _____ **Band** ____ **Guard** ____

◆ I, _____, hereby
PARENT(S)/GUARDIAN(S)
authorize the Head Chaperone of James Logan Band and Color Guard to give my student the following over-the-counter medications for headaches, cold and general aches and pains. I understand that I will be notified of any medications given to my child.

Below are over-the-counter medications that I have selected to give my child in my absence:

- Tylenol Advil Motrin Aspirin Cough Drops
 Sudafed Pepto-Bismol Cough syrup Benadryl Antacid

◆ I, _____, hereby
PARENT(S)/GUARDIAN(S)
authorize the Head Chaperone of James Logan Band and Color Guard to **NOT** give my student any over-the-counter medications for headaches, cold and general aches and pains at any time. I understand that I will be notified in case of illness.

◆ **PRESCRIPTION MEDICATIONS**

Please indicate what your child is currently taking:

Medication: _____ Reason for Medication _____
Dosage: _____ Time(s) to be dispensed _____

Medication: _____ Reason for Medication _____
Dosage: _____ Time(s) to be dispensed _____

◆ **ALLERGIES**

Please indicate what your child is allergic to and the severity of an allergic reaction:

◆ _____
Parent/Guardian Signature

Date

over →

STUDENT MEDICAL INFORMATION

◆ Student Name: _____ ID# _____

Address: _____ City _____ Zip _____

Home Telephone #: () _____ Cell Phone#: _____

*I give permission for the above named student to receive any necessary emergency medical treatment while traveling or participating with the **James Logan Band and Color Guard**. To the best of my knowledge, my child has no medical problems that would prohibit my child from participating fully in strenuous physical activity. I agree to assume all financial responsibility for any costs incurred.*

Parent/Guardian Signature _____ Date _____

PARENT/GUARDIAN INFORMATION

◆ Father/Guardian: _____

Cell Phone # or Pager #: () _____

Email Address: _____

◆ Mother/Guardian: _____

Cell Phone # or Pager #: () _____

Email Address: _____

EMERGENCY MEDICAL/DENTAL INFORMATION AND INSTRUCTIONS

MEDICAL INSTRUCTIONS: Please include special health considerations or other important information. Use separate sheet of paper if necessary. **NOTE:** If none, please indicate "NONE":

◆ Medical Insurance Carrier: _____

Medical Group Number: _____

Physician Name: _____

Physician's Telephone #: () _____

◆ Dental Insurance Carrier: _____

Dental Group Number: _____

Dentist Name: _____

Dentist Telephone #: () _____

OTHER EMERGENCY CONTACTS

◆ Name/Relationship _____

Home Telephone #: () _____ Cell Phone# or Pager#: _____

◆ Name/Relationship _____

Home Telephone #: () _____ Cell Phone# or Pager#: _____