

RUCKEL MIDDLE

SCHOOL CHORUS

EMERGENCY MEDICAL

LAST NAME

TREATMENT AND CONSENT FORM

Email: _____

Parent's or Guardian's Medical authorization for students participating in and traveling with the Ruckel Middle School Chorus. This authorization is good for the entire school year, from August, 2021 through June, 2022.

Part 1 – Student's Personal and Family Information

Name _____ Grade _____
Address _____ Sex M/F
_____ Birth Date: _____
Home Phone _____ Emergency Phone _____

FATHER's Name _____ Military? Y/N Cell Phone _____

MOTHER's Name _____ Military? Y/N Cell Phone _____

Person to call if Parents not available: _____ Phone _____

Medical Insurance Provider _____ Policy Number (or spouses SSAN _____)

Part 2 – Student's Medical History

History of (CIRCLE):	Asthma	Diabetes	Epilepsy	Fainting	Head Injury
Heart Trouble	Hemophilia	Kidney Trouble	Rheumatic Fever		
Allergies (if yes, to what? _____)	Epi Pin? Y N	Glasses	Contacts		
Is the student on a long-term medical program? Y N	What program? _____				
Year of last Tetanus Booster _____	Immunizations Current? Y N				

IMPORTANT: ON THE BACK, LIST PAST SURGICAL HISTORY AND CURRENT MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER)

Part 3 – Parental Preferences

May the student be given the following over-the-counter medications by chorus staff or chaperons?
Tylenol (acetaminophen) – Y N Benadryl – Y N Pepto Bismol - Y N Immodium AD - Y N
Advil (ibuprofen) - Y N Sudafed PE - Y N Tums - Y N Gas-X - Y N

Note: Any medication brought by the student for administering at a chorus function must be clearly labeled with the student's name, dosage, and time to be given. Medication will be held by the chorus director, staff, or designated chaperon during chorus functions.

Part 4 – Activity and Treatment Limitations

Permission to participate in CHORUS overnight trips-----Y N

Permission to participate in CHORUS water activities-----Y N

Permission for emergency medical treatment of student by EMS
Personnel, physician, or hospital emergency room staff.

(If no, explain below)-----Y N

Limitations of medical treatment beyond those given in Part 3: _____

Note: If the student has any contagious disease, serious illness, or recent accidents, or if any of the above medical information changes, please notify the chaperon or chorus staff traveling with the chorus.

I have read and understand the information provided in this form and agree to the terms and conditions of the activity. I understand that I am responsible for providing accurate information and for notifying the chorus staff of any changes in my medical information.

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Year of last Tetanus Booster: _____

ON THE BACK LIST PAST SURGICAL HISTORY AND CURRENT MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER). If you have any allergies, please list them below. If you have any other medical conditions, please list them below.

NAME OF EVENT: CHORUS ACTIVITY **DESTINATION:** RECONVENT AFA **ANTICIPATED PERFORMANCES:**

Designated Supervisor of Activity: _____

Date and Time of Departure: SATURDAY, FEBRUARY 20, 2010 **Date and Anticipated Time of Return:** SUNDAY, FEBRUARY 21, 2010

Student Cost: _____ **Method of Transportation:** SCHOOL BUS

If you would like your child to participate in this school activity, please complete, sign, and return the following permission form to me by _____ (date). As parent or legal guardian, you remain fully responsible for any legal responsibility which may result from any personal actions taken by the named student.

Part 5 – PERMISSION TO ADMINISTER CARE

As a parent or guardian, I consent to the medical admission of the student named in Part 1 and to such general and/ or acute nursing care, medication, medical diagnostic tests, blood products, and other general care determined to be necessary by the attending physician, except as described in Part 4. This consent applies to the use of emergency life-saving procedures should such procedures prove necessary. This consent allows for designated CHORUS chaperones access to this form for medical needs and administering prescription and OTC medications in circumstances where advanced medical treatment may not be needed.

DATE: _____

SIGNATURE (in the presence of a NOTARY) : _____

For NOTARY:

STATE OF FLORIDA, COUNTY OF OKALOOSA

This instrument was acknowledged before me this _____ day of _____, 20__

(date) by _____ (name), who is personally known to me or who has produced _____ (type of identification) and who did/did not take an oath.

NOTARY PUBLIC