KENT CITY BANDS MEDICAL EMERGENCY INFORMATION/HEALTH FORM/POLICIES FORM

STUDENT INFORMATION (PLEASE PRINT LEGIBLY)

Student's Name:_____

Phone # _____ Cell Phone #_____

Mailing Address:_____

Student's Email:_____

PARENT/GUARDIAN INFORMATION (PLEASE PRINT LEGIBLY)

Mother/Guardian: _____ Father/Guardian: _____

Home Phone#_____ Home Phone# _____

Work Phone #_____ Work Phone #_____

Cell Phone #_____ Cell Phone #_____

Parent/Guardian E-mail_____

EMERGENCY INFORMATION:

_____

Person to be notified in an emergency relationship phone

Insurance Information:

_____

Insured Name Company Policy Number

MEDICAL HISTORY (PAST AND PRESENT PROBLEMS OF IMPORTANCE)

1) Allergies:
2) Medication being used (include dosage and frequency)
3) Any health problems of possible significance:
4) Any other medical information considered important:
5) Doctor: _____ Phone # _____

----------PLEASE FILL OUT THE BACK OF THIS FORM----------

NON-EMERGENCY TREATMENT PERMISSION

In the event of a non-emergency, medical situation the undersigned hereby grants authority to be exercised at the discretion of the Kent City Music Staff / Music Boosters to administer over the counter medication at the proper, printed dosage to my son/daughter/student.

_____

Student Printed Name Date

_____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature Date

PLEASE PUT ALL PRESCRIPTION MEDICINES IN A CLEAR, ZIP-LOCKED BAG. CLEARLY LABEL THE BAG IN PERMANENT MARKER WITH YOUR STUDENTS NAME. THESE ITEMS SHOULD BE KEPT SEPARATE FROM THE LUGGAGE AND WILL BE TURNED INTO OUR NURSE. PLEASE CHECK INHALERS AND EPI-PENS ON July 15th SO WE ARE AWARE OF THEM AND THEY WILL BE HANDED RIGHT BACK TO THE STUDENT WHO NEEDS TO CARRY THEM ON THEIR PERSON.

ANY NON-PRESCRIPTION MEDICINES YOUR CHILD MAY NEED SHOULD CAN BE DONATED TO OUR CAMP HEALTH KIT IF SEALED. SIMPLY PURCHASE A BOTTLE, TUBE, OR BOX OF WHATEVER MEDICINE YOU ANTICIPATE YOUR SON OR DAUGHTER NEEDING AND BRING IT TO LUGGAGE CHECK. THIS WILL ENSURE THAN YOUR STUDENT HAS THIS ITEM IF NEEDED AND WILL KEEP THEM FROM VIOLATING THE NON-PRESCRIPTION MEDICATION RULES OF THE KENT CITY BANDS.

Parents and Guardians: Feel free to indicate below over the counter medications you anticipate your student needing while at camp. Many students will be in need of skin cleaning agents, sun burn relief, calamine, acetaminophen, Benadryl, tums, cough drops, etc… Your help in specifying items that your student is used to receiving can help our camp nurse meet the individual needs of your student. This is not required. OTC Med form as well.

MEDICINE	SYMPTOMS	DOSAGE

EMERGENCY TREATMENT PERMISSION

In the event of any emergency and we cannot reach the above mentioned people, the undersigned hereby grants authority to be exercised at the discretion of the Kent City Music Staff / Music Boosters to obtain whatever medical assistance and/or treatment that may be necessary for my child, the student named above.

I also grant permission for my child to attend any activities sponsored by the Kent City High School Band.

_____

Parent Signature Date

UNIFORM AND EQUIPMENT AGREEMENT

I will keep my uniform in great condition. If any repairs need to be made, I will advise a music booster. I understand that my uniform, hat and shoes are to be kept in the band room storage area after each performance. If any portion of my uniform is not returned at the end of the year or is returned in an irreparable condition, I understand that I will be required to pay a replacement fee for that piece(s).

During marching season, I also understand that it is my responsibility to attend all performances (competitions, football games, parades, etc.) dressed in proper attire such as ALWAYS wearing black socks, black marching band shoes, compression gear, and black gloves. During concert season, I understand that it is my responsibility to attend all performances dressed in proper attire which includes black socks or black nylons with black shoes and my self-provided concert uniform. In addition, I realize that I am responsible for any equipment I am issued for use and that I may be charged for its loss or damage.

_____

Student Signature Date

_____

Parent Signature Date

PERMISSION FORM FOR PRESCRIBED MEDICATION

Kent City High School
351 N. Main
Kent City, MI 49330
Phone: 616-678-4210 Fax: 616-678-4371

Date form received by school: _____

Student: _____ Date of birth: _____ Grade: _____

To be completed by the physicians or authorized prescriber

Name of medication: _____

Reason for medication: (optional) _____

Form of medication/treatment: __Tablet/capsule __Inhaler __Injection __Nebulizer __Other_____

Instructions (Schedule and dose to be given at school): _____

_____

Start: ___ Date form received Other dates: _____

Stop: ___ end of school year Other date/duration: _____

_____ For episodic/emergency events only

Restrictions and/or important side effects: ___ None anticipated
___ Yes, please describe: _____
Special storage requirements: ___ None ___ Refrigerate ___ Other: _____

This student is both capable and responsible for self-administering this medication:
___ No ___ Yes – supervised ___ Yes – unsupervised

This student may carry this medication: ___ No ___ Yes

Please indicate if you have provided additional information: ___on the back side of this form
___ as an attachment

Date: _____ Signature: _____

Physician's name: _____
Address: _____
Phone Number: _____

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-administer the above medication at school according to the school policy.

Date: _____ Signature: _____ Relationship: _____

Band Camp Medical Information *Confidential*

Over the Counter Medication Authorization

Student's Name _____ Date of Birth _____

I (parent/guardian) hereby give permission for camp staff to administer the following over-the-counter medications or generic equivalents if the on site health care staff deems it necessary. Dosages will be administered according to directions on the product.

_____ Acetaminophen/Tylenol (headache, menstrual cramps, muscle cramps, fever)

_____ Ibuprofen (headache, menstrual cramps, muscle cramps, fever, ear aches)

_____ Tecnu/Rhullgel/Ivy Dry/Calamine lotion (poison ivy, bug bites)

_____ Ludens Throat drops/Cipacol lozenges/Chloraseptic (sore throat)

___ Sudafed liquid or tablets (stuffy nose)

_____ Pepto-Bismol/Tums/Rolaids (upset stomach/diarrhea)

_____ Benadryl - liquid or lotion (insect bites, allergy symptoms, allergic reaction)

_____ Triple Antibiotic Cream/Neosporin (skin abrasions/minor cuts and burns)

_____ Hydrocortisone cream (insect bites, sunburn)

_____ Foille/Solarcaine (sunburn)

_____ Hydrogen Peroxide / Iodine (minor cuts, scrapes, burns)

_____ Campho-Phenique (cold sores, insect bites, sunburn)

Signed _____ Date _____
Parent/Guardian

Print Name: _____

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

	Symptoms of Anaphylaxis
MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath, cough, wheeze
HEART*	weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐ Adrenaclick (0.15 mg) ☐ Adrenaclick (0.3 mg)

☐ Auvi-Q (0.15 mg) ☐ Auvi-Q (0.3 mg)

☐ EpiPen Jr (0.15 mg) ☐ EpiPen (0.3 mg)

Epinephrine Injection, USP Auto-injector- authorized generic
☐ (0.15 mg) ☐ (0.3 mg)

☐ Other (0.15 mg) ☐ Other (0.3 mg)

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ **work**_____ **cell**_____

Emergency contact #2: home_____ **work**_____ **cell**_____

Emergency contact #3: home_____ **work**_____ **cell**_____

Comments: _____

_____

_____
Doctor's Signature/Date/Phone Number

_____
Parent's Signature (for individuals under age 18 yrs)/Date