# 2018-19 Limestone Bands
# Medical Information &
# Parents' Consent and Authorization for Travel

Return by 5/1/2018

Student's Full Name _____ Preferred Name _____

Parent(s)/Guardian(s) _____

Address _____

2nd Address (if needed) _____

Telephone Numbers

Student Cell _____ Home Phone _____

Mother Cell _____ Mother Work _____

Father Cell _____ Father Work _____

Is he/she allergic to any medicine or drug? YES or NO
If yes, please provide name of medication and describe reaction to:

_____

_____

Is he/she allergic to any food or beverages? YES or NO
If yes, please provide name of food or beverage and describe reaction to:

_____

_____

Is he/she allergic to any insect bite such as bee, wasp, etc.? YES or NO
If yes, please provide reaction to insect bite:

_____

_____

*Note:* If your child needs specialized medical equipment, such as epinephrine kit or inhaler, it is your responsibility to provide the equipment.

Has he/she had a tetanus shot? YES or NO If Yes, when? _____

Blood Type (if known) _____ Birth Date _____

Medications being taken (please list the name, dose, and how often)

_____

_____

Will your student have prescription medication(s) with them that you would like for the student to notify staff before taking? If so, please provide name of medication:

_____

Physician _____ Phone _____

Hospital Requested to Provide Care:

_____OSF St Francis Medical Center _____Unity Point (formerly Methodist)

_____Proctor Hospital _____Pekin Hospital

Medical Insurance Provider _____ Policy Holder Name _____

Policy Number _____ Group Number _____

In case we are unable to reach you, please provide an Alternate Emergency Contact and phone number:

_____

Any addition instructions for emergency medical treatment _____

_____

We have the following non-prescription medications that may be provided to your child if he/she requests, if we feel that it is appropriate, and if you give your permission. Please **circle each medicine** that you allow us to give to your child:

| | | |
|---|---|---|
| Motrin (ibuprofen) | Tylenol (acetaminophen) | Tums |
| Excedrin Migraine | Benadryl | Imodium |

Would you like us to call you before giving the approved medicine(s)? (**If you mark "Yes," we will be unable to give the above medicine without speaking with you first.)** YES or NO

If Yes, please provide the best contact number to contact you and whom we are contacting.

_____

Are there any specific questions you would like us to ask your child before giving medicine you have given approval for? If so, please provide questions and directions:

_____

_____

Any other medical information, such as existing or chronic diseases or medical problems, that you feel is important for staff to be aware of for the best interest of your child:

_____

_____

**I hereby grant permission for my child to participate in band activities, including travel outside of the LCHS area. I give permission for the above circled medications to be provided to my child per my written instructions. In the event of accident or medical illness, permission is granted for any such medical and/or surgical treatment as may be necessary. I understand that every effort will be made to notify me before any major treatment is undertaken.**

_____ _____

Parent or Guardian Signature Date