Flowery Branch Pã @ÁÙ&@[|ÁT æ&@ * ÁÓæ} åÁÈÙč å^} óÁT ^åã&æþÁ*
Ø[¦{ • Please complete all <u>**THREE PAGES**</u>

Student Information

Name: ____ Date of Birth: ______________
mm/dd/yy

Student Cell #: _____________________________ Home Phone #: _______________________
If available

Home Address: ____

____

Contact Information to call In Case of Emergency: (Please include all relevant information)

Name: ____ Relationship: ______________

Home Phone #: ______________ Cell Phone #: _________________ Wk Phone #: __________

Name: ____ Relationship: ______________

Home Phone #: ______________ Cell Phone #: _________________ Wk Phone #: __________

Emergency Contact (person to contact if persons listed above cannot be reached in emergency)
If contacts listed above cannot be reached in the event of an emergency, the following person is authorized to act in my behalf:

Name: ____ Relationship: ______________

Home Phone #: ______________ Cell Phone #: _________________ Wk Phone #: __________

Physician Information:

Physician's Name: ________________________________ Phone #: ______________________

Additional remarks: ____

Prescription Medications

☐ Takes NO medications on a routine basis. ☐ Takes prescription/over-the-counter medications

List Prescription/over-the-counter medications here. **Bring meds in pharmacy-issued container(s):**

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Student Name: ____ Date of Birth: ______________ *mm/dd/yy*

Allergies

Please list any known allergies, illnesses, injuries, possible conditions, or anything else that may affect this student's health & welfare during this trip. Band Camp Personnel may offer over-the-counter medications (i.e aspirin, Tylenol, ibuprofen, cough drops, antacids, motion sickness meds, etc.) if needed, unless you indicate a problem with allergy to certain medications, or prefer that medication not be given:

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Immunization Statement (check one)

- ☐ My child has been tested for and immunized or protected against diseases specified by the director of the department of community health.
- ☐ My child has not been immunized due to religious convictions or other objection to immunization.
- ☐ My child is in the process of complying with all immunization requirements

Health Insurance Information:

Insurance Company Name: ____________________________________ Contract #: ________________

Subscribing member name: ______________________________ Group Name: ____________________ *If employer related*

Insurance Co. Contact Telephone #: _______________________ Group Number: __________________

Dental Insurance Information: ____

<u>If the adult has no health/dental insurance coverage</u>, please list the name and address of the financially responsible person and MI Driver's License Number as may be required for treatment:

Name: ____ Best Phone #: ____________________

Address: ____ Driver License #: _________________

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Student Name: ____ Date of Birth: _____________

mm/dd/yy

Over-the-Counter Medication Authorization

I (parent/guardian) hereby give permission for 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. (Check medications you approve of)

Brand name/generic name or active ingredient(s), route of administration, (treatment purpose)

_____ **Tylenol**/ acetaminophen, oral tablets (headache, menstrual cramps, muscle cramps, fever)

_____ **Advil/** ibuprophen, oral tablets (headache, menstrual cramps, muscle cramps, fever, ear aches)

_____ **Halls**/ menthol, oral cough drops (cough suppressant, oral anesthetic)

_____ **Sucrets**/ dyclonine HCL, oral throat lozenges (sore throat, oral anesthetic)

_____ **Pepto Bismol**/ bismuth subsalicylate, oral tablets or liquid (upset stomach, diarrhea)

_____ **Tums, Rolaids**/ calcium carbonate, magnesium hydroxide tablets (heartburn, acid indigestion)

_____ **Claritin**/ loratidine, antihistamine, oral tablets (runny nose, hay fever, allergy symptoms)

_____ **Zyrtec**/cetirizine, antihistamine, oral tablets (runny nose, sneezing, allergy symptoms)

_____ **Benedryl**/ diphenhydramine, topical cream, oral liquid or tablet (allergic reactions, hives, itching)

_____ **Neosporin/** triple-antibiotic, topical ointment (skin abrasions, minor cuts, burns)

_____ **Solarcaine, Bactine/** lidocaine HCL, topical liquid for pain (sunburn, minor cuts, burns)

_____ **Cortizone 10**/ hydrocortisone, topical cream (insect bites, minor itching and rashes)

_____ **Other** medications, as approved by parents by phone, if needed during camp

Acknowledgement and Consent

Parent/Guardian will be responsible for arranging payment of costs if not covered within the insurance policy. If no insurance is available, the parent is responsible for all costs incurred in emergency treatment, as deemed necessary by Flowery Branch ¦^] ¦^•^} cæã^• Áæ} å
by Medical Authorities who may be involved. Every effort will be taken to contact emergency contacts listed in an emergency, once the ill or injured child has been stabilized. Non-emergency situations will be discussed with chaperone and/or parent/guardian prior to medical treatment, unless minor.

I hereby give permission to the Flowery Branch nstructo¦s a} dÁchaperones to provide medical/dental treatment, when necessary, for the student listed on this form. Additionally, I give permission for FBHS instructors and chaperones to transport student, when necessary, using school and/or chaperone vehicles. I agree that the information provided on this form is accurate to the best of my knowledge, and agree to be responsible for financial considerations should medical/dental treatment be deemed necessary by school instructors or chaperones or medical professionals.

Guardian Name: ____________________________________

Signature: ____ Today's Date: ___________________