EMERGENCY MEDICAL RELEASE

Otsego High School
550 Washington Street
Otsego, Michigan 49078

NAME OF STUDENT: _____PHONE:_____

ADDRESS:_____

CITY/STATE/ZIP: _____

DATE OF BIRTH: _____ AGE: _____

PARENT'S OR GUARDIAN FULL NAME: _____

PHONE WHERE PARENTS OR GUARDIAN CAN BE REACHED:

MOTHER: (H)_____ (O)_____(C)_____

FATHER: (H)_____ (O)_____(C)_____

GUARDIAN: (H)_____ (O)_____(C)_____

EMERGENCY CONTACTS (in case parents cannot be reached):

NAME: _____PHONE: (H)_____

CELL:_____

NAME: _____PHONE: (H)_____

CELL:_____

FAMILY PHYSICIAN: _____ PHONE: _____

FAMILY MEDICAL INSURANCE CARRIER: _____

POLICY NUMBER: _____ PHONE: _____

MEDICAL HISTORY

LIST ALL DRUG ALLERGIES _____

_____

LIST ANY OTHER ALLERGIES (bee sting, foods, hay fever, etc.)

_____

LIST ANY MEDICAL PROBLEMS CURRENTLY UNDER TREATMENT (fainting, seizure, diabetes,etc): _____

_____

STUDENT'S BLOOD TYPE: _____DATE OF LAST TETANUS BOOSTER**:** _____

(con't on back)

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MEDICAL HISTORY (CON'T)

LIST OF CURRENT MEDICATIONS:

MEDICATION NAME	DOSAGE	FREQUENCY/ INSTRUCTIONS

Students will not be allowed to carry or administer their own medications for any reason. If you would like the band nurses/chaperones to administer over the counter drugs to your student, please fill out the list below. The band nurses will only follow the directions on the medicine containers unless otherwise noted on your child's medical form. **If your child uses an inhaler and/or epipen, they must carry it with them at all times and both will be carried and administered by students.** All other medications will be in the possession of, be monitored by, and be administered by the band nurses and chaperones ONLY! There will be consequences if students do not follow the medication policy.

Over the counter medications that can be administered:

Tylenol _____ Motrin_____ Immodium _____ Benadryl _____ Dramamine_____

Tums _____ Pepto-Bismol _____ Sudafed _____Cough Drops _____

Other (Please list): _____

_____

AUTHORIZATION TO RECEIVE MEDICAL TREATMENT

I, the parent (or legal guardian) of _____ hereby give permission to the band nurses to give over the counter drugs and prescribed medications to my child. I also hereby give permission to the licensed physician at a medical center or a hospital, to hospitalize, secure proper treatment, anesthesia or perform emergency surgery for my child.

_____ _____
Mother's signature Father's signature

_____ _____
Legal guardian signature Date signed

Please complete and return to Mr. Piersma no later than **Thursday, July 26, 2018.**