***Douglas Freeman High School Choirs: MEDICAL INFORMATION AND RELEASE***

|  |  |
| --- | --- |
| **Student Name** |  |
| **Parent Name** |  |
| **Parent Phone Number** |  |
| **Family Physician** |  |
| **Physician Phone Number** |  |
| **Student Insurance Provider** |  |
| **Policy Number** |  |
| **Group Number** |  |

|  |
| --- |
| ***List any allergies to foods or medications:*** |
|  |

|  |
| --- |
| ***List any other medical concerns:*** |
|  |

|  |
| --- |
| ***When the chorus travels, the chorus director and parent chaperones maintain a medical bad with over-the-counter (OTC) medications. Please indicate below your preference for your students:*** |

|  |
| --- |
| ***\_\_\_\_ My child cannot be given any OTC medications***  ***\_\_\_\_ My child can be given any OTC medication that is appropriate as determined by the chorus director or chaperone***  ***\_\_\_\_ My Child can only be given the following medications:***  ***\_\_\_ Ibuprofen (Advil)***  ***\_\_\_ Acetaminophen (Tylenol)***  ***\_\_\_ Loperamide HCL (Imodium)***  ***\_\_\_ Pseudoephedrine HCL (Sudafed)***  ***\_\_\_ Diphenhydramine HCL (Benadryl)***  ***\_\_\_ Meclizine HCL (Dramamine)***  ***\_\_\_ Calcium Carbonate (Tums)***  ***\_\_\_ Pepto Bismol*** |

|  |
| --- |
| ***In the event that I cannot be reached in a medical emergency, I hereby authorize any necessary medical treatment for student named above while participating in the DSF High School Chorus Program. I also guarantee payment of all charges incurred during that treatment including but not limited to ambulance, physicians, hospital charges, lab work, and medications.***  ***Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |