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

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

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| ***List any allergies to foods or medications:***  |
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| ***List any other medical concerns:***  |
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| ***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:***  |

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| ***\_\_\_\_ 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*** |

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| ***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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |