

Mohonasen Central School District
Band, Choir and Orchestra Medical/Emergency Information Form
High School Students Grades 6– 12

Student _____ For School Year: _____ (Need new form completed by parent if any changes during the year)
 Parent/Guardian _____ Phone Home _____ Work _____
 Address _____ Cells _____
 Primary Physician _____ Phone _____
 Insurance Carrier _____ Policy # _____

Emergency Contacts:

Name _____ Phone _____ Relationship _____
 Name _____ Phone _____ Relationship _____

*****ALL MEDICATIONS WILL NEED A PHYSICIAN WRITTEN ORDER ATTACHED******

Is your child currently on medication? Yes ___ No ___ Allergies (medications/food etc.) _____
 Medication _____ Reason _____ Dose/Time _____
 Medication _____ Reason _____ Dose/Time _____
 Medication _____ Reason _____ Dose/Time _____

Will your child need to take any of the above medication during these trips? Yes ___ No ___

If “Yes” please read and initial **ONLY** the appropriate section/s below pertaining to your child’s needs.

****ANY MEDICATION WILL NEED A PHYSICIAN WRITTEN ORDER ON FILE IN THE NURSES’S OFFICE****

___ I will provide a **WRITTEN ORDER** for his/her medication from a licensed prescriber for **ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATION** stating the child’s name, dose and time to be administered, reason for prescribing and any adverse reactions. **All prescription medication must be in a pharmacy labeled container and all non-prescription medication (over the counter) must be in its original unopened manufacturer’s container with the student’s name affixed to the container.**

___ My child is **self-directed**, capable and competent to understand and correctly administer the medication each time it is required with the assistance of an appropriate chaperone (parent/guardian, family appointed member, instructed school staff member). **Except for diabetics any medication other than an asthma inhaler and an Epi-pen need to be in the possession of the adult chaperone during the field trip.**

___ My child **requires an injectable medication** (except Epi-pen and insulin) and will require a nurse/parent/guardian/parent designee to be in attendance.

___ My child is **diabetic** and allowed to carry all diabetic supplies on their possession and will require a nurse/parent/guardian/parent designee or glucagon trained staff member to be in attendance.

___ My child is self directed and required to have an **Epi-Pen** on their possession for a **severe hypersensitivity** and he/she is knowledgeable and capable of when and how to self-inject and will notify the nearest adult to call 911. If necessary, any school staff member responding to the life threatening situation may administer the Epi-Pen covered under the “Good Samaritan Act”.

Please include any other medical information or concerns. _____

If in my absence and if I cannot be contacted in the event of a life-threatening medical emergency, I being the parent/legal guardian of the above named minor do hereby give permission for any emergency medical, dental or surgical care to be given. I assume all responsibility for this designation and hold the school district harmless from any liability that may result from this designation.

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

**** Please note this form will be kept on file and it is the parent/guardian’s responsibility to update any changes to this form (medication, emergency contact numbers etc.) throughout the school year.**