



Frank W. Cox Marching Band and Color Guard
Medical Information/Treatment Form

Date: _____

This is to certify that (print) _____ has my permission to travel to all music festivals and other related trips during the 2019-2020 school year with the Cox HS Band.

Health Information: Check all that apply:

_____ Asthma _____ Allergies _____ Diabetes _____ Wear Contacts _____ Arthritis
_____ Migraines _____ Seizures _____ Nose Bleeds _____ Convulsions _____ Other

Explain Checked Boxes and Identify Any Other Health Concerns:

Parent/Guardian: Name: _____

Phone: (home) _____ (cell) _____

Emergency Contact: Name: _____

Phone: (home) _____ (cell) _____

Request for Administering Prescription Medications to Students: (Medications must be in pharmacy container with prescription label properly affixed to the medicine in question.)

_____ I request that my child be allowed to take the prescription medicine, _____ as prescribed by our physician while on band trips.

_____ I request that my child be allowed to carry and use a self-administered metered dose inhaler containing rescue medication and/or an Epi-Pen as prescribed by our physician.

Administration of Over-the-Counter ("OTC") Medication: (OTC medications must be in original container and used according to physician's signed written directions which must be attached to this document.)

Further explanation is contained in Part III of the Booklet.

_____ I give permission for a Cox HS representative to administer _____ to my child according to the recommended dosage instructions.

_____ I give permission for my child to carry _____ and consume or apply this medication(s) as directed by our physician.

My student and I have read, understand, and agree to abide by the requirements set forth in this agreement and all other expectations and rules set forth by the Virginia Beach School District and its representatives, including those accompanying students on band trips. I further agree that in any emergency, any Frank W Cox representative may transport my child to a hospital/medical facility, and I authorize any physician or other medical personnel to carry out any diagnostic or emergency care deemed necessary.

Parent/Guardian name (Print)

Parent/Guardian Signature

Student Name (Print)

Student Signature