West Des Moines Community School District
Student Out of District Travel Health Information
(Please Print)

Authorization for Health Care

This form provides information for use in case medical care is necessary or advisable during travel out of district. Information will be kept in strict confidence and will be used only if necessary by authorized adults.

If your student has a special medical problem which occurs after this form is completed and at the time of the trip, please inform the school nurse so that arrangements may be made for the student's medical care. If your student will need medication on any trip the band may take, the Authorization to Administer Medication (page 2) must be completed and signed.

If your student has a special medical problem at the time of any given band trip, please notify the chaperone chairperson, band booster president or one of the directors.

Grade of Student: _____ Band: March Masters / Concert / Symphony / Jazz Color Guard: yes / no

Instrument(s): _____

Student's Name: _____Date of birth: _____

Parents/Guardians: _____

Address: _____

City/Town: _____ State: _____ ZIP Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Cellular Telephone Number: _____ E-mail Address: _____

I/We hereby give my/our permission for the above named student to attend the school sponsored event(s) and acknowledge that all school rules relative to student behavior are in effect throughout the trip.

_____

Parent/Guardian Signature(s) Date

Emergency Contact Information of Parents/Guardians

Where can you be contacted in case of emergency? I can be contacted at home or work: _____ Mom / Dad

If Parent/Guardian is not able to be reached, contact: _____

Health Care Treatment/Information

Please list all medication your child takes on a regular basis: _____

Please list all allergies that your child has to: Drugs: _____ Foods: _____

Environmental: _____ Bee stings (include reaction): _____

Does your child have asthma? Yes / No If yes, does he/she carry an inhaler? Yes / No

Does your child wear contact lenses? Yes / No Date of most recent tetanus immunization: _____

Does your child have fainting/dizzy spells? Yes / No Convulsive seizures? Yes / No Has your child had any intestinal/stomach disorders? Yes / No

Please list any previous surgeries/dates: _____

Does an adult chaperone or school staff member have permission to give your child medication? Yes / No

If yes, please circle the medication that may be given: Tylenol 500-1000mg / Ibuprophen 200-400mg / Tums / Dramamine / Sudafed

WE CANNOT AND WILL NOT BE RESPONSIBLE FOR MEDICATIONS YOUR STUDENT TAKES THAT HAVE BEEN GIVEN TO HIM/HER BY ANOTHER STUDENT

In case of illness or accident, I/We request that necessary medical/dental care be instituted. I/We hereby give my/our consent for emergency treatment until I/We can be reached. I/We certify under penalty of perjury, and pursuant to the laws of the State of Iowa, that the preceding is true and correct and that I/We am/are the parent/guardian of the above-named student.

_____ _____

Date Parent/Guardian

Authorization to Administer Medication

This form must be signed by the parent/guardian to authorize the administration of **ANY** medication that is being sent for the student who is participating in the trip. Medication must be in an original pharmacy container with a pharmacy label listing child's name, medication name, dosage, time. **(Please complete the below as applicable).**

Student Name: _____ Date of Birth: _____

Personal Physician: _____ Phone: _____

Personal Dentist: _____ Phone: _____

Medication will be kept and administered to your student by the teacher/chaperone in charge.

Please give above named student the following medication:

Name of medication: _____

Comments: _____

_____.

I request that the prescribed medication be administered according to written directions on the original container.

_____ _____

Date Parent/Guardian