

2009-10 TEMPORARY MEDICAL GUARDIANSHIP

I (we) the undersigned, _____, are the natural parents or legal guardians of _____ (please print). During our absence he/she has been placed in the temporary care of MARCUS HIGH SCHOOL BAND, who is/are empowered by this statement to call for and authorize medical care and assistance in the event of injury, accident or illness involving our child or children. It is my (our) intention that this statement serve as authorization for such medical care to be administered during the following period of time:

Beginning Date 1 Aug 2009 through the Ending Date 31 Jul 2010.

In the event that further medical consultation is required, the **physician** who has most recently examined the child/children is: Doctor _____ Phone # _____ Child DOB: _____

PARENT(S)/ LEGAL GUARDIAN NAMES: _____

Parent Contact Numbers: Primary Home _____ Mother cell _____
Mother work _____ Father cell _____ Father work _____
Other (list) _____

Emergency Contact Numbers: *The following individuals are also authorized to give consent for treatment of this student if the parent/legal guardian cannot be reached in the case of an emergency:*

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

Known Allergies: Drugs _____ Foods _____ Last Tetanus _____

PRINT all medical conditions, history of surgeries, and serious injuries: _____

PRINT Names and Doses of all regular medications: _____

Insurance information: Company _____ Policy # _____

LISD DRUG POLICY

LISD Policy allows for students to keep prescription and/or over-the-counter medications with parental permission. Such medications will require that students have a note with dosing instructions signed by their parent/guardian. Common over-the-counter medications are listed in the next section and can be permitted by parents with this form. If preferred, medications and instructions may be given to a director/chaperone to be dispensed as needed. Students may **not** share any medications under any circumstances. All **controlled** substances, such as narcotic pain medications, Ritalin, etc., **must** be collected by the directors/designated head chaperone with appropriate dosing instructions signed by the parent/legal guardian. **All** medications must be in the original containers.

PRIVACY STATEMENT

For your information, please be advised that all information on this form will only be used to assist in obtaining emergency medical treatment.

*This signed form may serve the purpose of providing parental permission for the following over-the-counter medications: *PLEASE NOTE that the student is required to provide these medications. The following allows for the student to carry and take the medications listed without an additional note from the parent. My child has permission to take the following over-the-counter medications in recommended dosages (as noted by manufacturers) unless otherwise indicated below (check all that apply):*

____ Acetaminophen (Tylenol) ____ Ibuprofen (Motrin, Advil) ____ Digestive Relief (Chewable antacids, Pepto Bismol)

I have read and understand the above information, including the LISD Drug Policy, Privacy Statement, and Over-the-Counter medication permission section.

Parent/Legal Guardian Signature _____ **Student Signature** _____