# LIONS OF MICHIGAN ALL-STATE BAND MEDICAL FORM

*(This information will be kept confidential)*

**STUDENT'S NAME**_____**NICKNAME**_____**SEX**_____**BIRTHDATE**_____

**ADDRESS**_____**CITY**_____**ZIP**_____**PHONE**_____

**PARENT/GUARDIAN**_____**WORK PHONE**_____**CELL**_____

**EMERGENCY CONTACT (other than parent)**_____**PHONE**_____

**PHYSICIAN**_____**PHONE**_____**INSURANCE CO.**_____

*****ALLERGIES TO MEDICATION NO**_____**YES**_____**LIST**_____

**ENVIRONMENTAL NO**_____**YES**_____**LIST**_____

**FOOD ALLERGY NO**_____**YES**_____**LIST**_____

*****MEDICATIONS --- ALL MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER) MUST BE GIVEN TO THE MEDICAL TEAM AT BAND CAMP CHECK-IN FOR DISPENSING AT THE DESIGNATED TIMES. (EXCEPTIONS ARE INHALERS AND EPI-PENS. PLEASE SEE MEDICAL TEAM.) MEDICATION MUST BE SENT IN THEIR ORIGINAL CONTAINERS AND LABELED FOR THIS STUDENT. STUDENTS ARE RESPONSIBLE FOR REPORTING TO THE MEDICAL TEAM FOR MEDS AT THE APPROPRIATE TIMES.**

| MEDS & INHALERS | DOSE | FREQUENCY | AS NEEDED | REASON FOR MED |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

***NOTE--THE MEDICAL TEAM STOCKS THE FOLLOWING MEDICATIONS. PLEASE DO NOT SEND ADDITIONAL AMOUNTS:***

ACETAMINOPHEN (TYLENOL)
ANTACID
ANTIBIOTIC OINTMENT
COUGH SUPPRESSANT
HYDROCORTISONE CREAM
IBUPROFEN
DECONGESTANT
DIPHENHYDRAMINE (BENADRYL)
LAXATIVE
IMODIUM (ANTI DIARRHEA)
SINUS TABS
MOTION SICKNESS MED
LOZENGES

## REQUIRED:

____You have my permission to administer any of the above over-the-counter meds if deemed necessary by the medical team EXCEPT _____ OR

____You DO NOT have my permission to administer any of the above over-the-counter meds.

PARENT/GUARDIAN INITIAL _____

**Does your student have any of the following conditions? (Please check all that apply)**

_____ Asthma/Wheezing
_____ Convulsions/Seizures
_____ Heart trouble/Murmur
_____ Diabetes
_____ Skin rash
_____ Frequent sore throat
_____ Frequent ear aches
_____ Depression

_____ ADHD
_____ High Blood Pressure
_____ Motion Sickness
_____ Anxiety/Panic attacks

Other - please explain:
_____
_____
_____
_____

*** PLEASE ATTACH COPY OF HEALTH INSURANCE INFORMATION.** (REQUIRED)

Each band member must secure and provide written proof of hospital and medical insurance for the duration of the LMASB experience.

*** PLEASE ATTACH A COPY OF YOUR STUDENT'S IMMUNIZATION RECORD.** (REQUIRED)

Date of last Tetanus_____

**I HEREBY AUTHORIZE A DOCTOR TO TREAT MY CHILD IF TAKEN TO A MEDICAL FACILITY. I FURTHER AUTHORIZE THE LIONS OF MICHIGAN ALL STATE BAND MEDICAL TEAM TO ACT IN MY BEHALF IN AN EMERGENCY SITUATION.**

_____
Parent/Guardian signature Date

**WE ATTEST THAT THE INFORMATION ABOVE IS CORRECT AND ACCURATE AS OF TODAY.**

_____ _____
Student signature Date Parent/Guardian signature Date