Grand Haven High School Band Camp Medical Information **(Please complete both pages)** *Confidential*

Student Information

Name: _____ Date of Birth: _____ *mm/dd/yy*

Student Cell #: _____ If available Home Phone #: _____

Home Address: _____

Contact Information to call In Case of Emergency: (Please include all relevant information)

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Wk Phone #: _____

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Wk Phone #: _____

Emergency Contact (person to contact if persons listed above cannot be reached in emergency). If contacts listed above cannot be reached in the event of an emergency, the following person is authorized to act in my behalf:

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Wk Phone #: _____

Physician Information:

Physician's Name: _____ Phone #: _____

Additional remarks: _____

Prescription Medications

☐ Takes NO medications on a routine basis. ☐ Takes prescription/over-the-counter medications

List Prescription/over-the-counter medications here. **Bring meds in pharmacy-issued container(s):**

_____

_____

Allergies: Please list any known allergies, illnesses, injuries, possible conditions, or anything else that may affect this student's health & welfare during this trip. Trip personnel may offer over-the-counter medications (i.e aspirin, Tylenol, ibuprofen, cough drops, antacids, motion sickness meds, etc.) if needed, unless you indicate a problem with allergy to certain medications, or prefer that medication not be given:

_____

_____

Over-the-Counter Medication Authorization: I (parent/guardian) hereby give permission for staff to administer the following over-the-counter medications or generic equivalents if the on-site health care staff deems it necessary. Dosages will be administered according to directions on the product. (Check medications you approve of)

Brand name/generic name or active ingredient(s), route of administration, (treatment purpose)

☐ **Tylenol**/ acetaminophen, oral tablets (headache, cramps, fever)

☐ **Advil/** ibuprophen, oral tablets (headache,cramps, muscle cramps, fever, ear aches)

☐ **Halls**/ menthol, oral cough drops (cough suppressant, oral anesthetic)

☐ **Sucrets**/ dyclonine HCL, oral throat lozenges (sore throat, oral anesthetic)

☐ **Pepto Bismol**/ bismuth subsalicylate, oral tablets or liquid (upset stomach, diarrhea)

☐ **Tums, Rolaids**/ calcium carbonate, magnesium hydroxide tablets (heartburn, indigestion)

☐ **Claritin**/ loratidine, antihistamine, oral tablets (runny nose, hay fever, allergy symptoms)

☐ **Zyrtec**/cetirizine, antihistamine, oral tablets (runny nose, sneezing, allergy symptoms)

☐ **Benedryl**/ diphenhydramine, topical cream, oral liquid/tablet (allergic reactions, itching)

☐ **Neosporin/** triple-antibiotic, topical ointment (skin abrasions, minor cuts, burns)

☐ **Solarcaine, Bactine/** lidocaine HCL, topical liquid for pain (sunburn, minor cuts, burns)

☐ **Cortizone 10**/ hydrocortisone, topical cream (insect bites, minor itching and rashes)

☐ **Other** medications, as approved by parents by phone, if needed during camp

☐ **Dramamine**/ (dimenhydrate) pill form for motion sickness.

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mm/dd/yy

Immunization Statement (check one)

☐ My child has been tested for and immunized or protected against diseases specified by the director of the department of community health.

☐ My child has not been immunized due to religious convictions or other objection to immunization.

☐ My child is in the process of complying with all immunization requirements

You must include a photocopy of your insurance card--front and back for claims instructions *and* complete insurance information *or* complete driver's license info below if no insurance

Health Insurance Information:

Insurance Company Name: _____ Contract #: _____

Subscribing member name: _____ Group Name: _____
If employer related

Insurance Co. Contact Telephone #: _____ Group Number: _____

Dental Insurance Information: _____

If the adult has no health/dental insurance coverage, please list the name and address of the financially responsible person and MI Driver's License Number as may be required for treatment:

Name: _____ Best Phone #: _____

Address: _____ Driver License #: _____

NOTE: If you or your child have symptoms, or have been in contact, or have been diagnosed with COVID-19, you may not be allowed to participate in summer rehearsals/band camp.

Acknowledgement and Consent: Parent/Guardian will be responsible for arranging payment of costs if not covered within the insurance policy. *I grant permission for emergency medical treatment.* If no insurance is available, the parent is responsible for all costs incurred in emergency treatment, as deemed necessary by Grand Haven Area Public School (GHAPS) representatives on the trip and by Medical Authorities who may be involved. Every effort will be taken to contact emergency contacts listed in an emergency, once the ill or injured child has been stabilized. Non-emergency situations will be discussed with chaperone and/or parent/guardian prior to medical treatment, unless minor.

I hereby give permission to the GHAPS instructors and chaperones to provide medical/dental treatment, when necessary, for the student listed on this form. Additionally, I give permission for GHAPS instructors and chaperones to transport student, when necessary, using school, chaperone, or other vehicles. I agree that the information provided on this form is accurate to the best of my knowledge, and agree to be responsible for financial considerations should medical/dental treatment be deemed necessary by school instructors or chaperones or medical professionals. Additionally, I consent to my child receiving daily health and temperature screenings to monitor COVID-19 symptoms if symptoms are present or student has been exposed to COVID-19.

The information submitted herein is truthful to the best of my knowledge. Further, in consideration of my/my child's participation with/in the Grand Haven High School Bands, I/we do waive any and all claims, suits, losses, actions, or causes of action against GHAPS, its employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk (including COVID-19 risks), accident, negligence, or otherwise, during or arising in any way from my/my child's participation in a GHAPS-sponsored band event. I/we understand that I am/we are expected to adhere firmly to all established band policies of the Grand Haven Bands. By typing my name and signature below and returning this form electronically, I agree that this consent is legally binding. Additionally, I acknowledge that I may print this form and returned a signed paper copy if preferred.

Guardian Name: _____

Signature: _____ Today's Date: _____