STUDENT'S NAME: _____
Last First Middle

INSURANCE NAME: _____ GROUP: _____

BRYAN HIGH SCHOOL BAND
CONSENT FOR MEDICAL TREATMENT

REQUESTS:
TO WHOM IT MAY CONCERN:

I, the undersigned, being the parent, legal next of kin, or the legal guardian of:

_____ _____ _____
Name of student Date of Birth Grade

Medical Release:
I, hereby, authorize a Bryan ISD representative:

1. To represent me before any medical institution where it may be necessary to send my student while he/she is under their care.
2. To give, in my name, the necessary authorization for surgery in case of emergency, when medical authorities deem it indispensable.
3. To represent me while my student is under their custody and control.

Permission to Administer "Over the counter" Medications:
I also grant permission to a Bryan ISD representative to administer "over-the-counter" medication (Ibuprofen, Acetaminophen, Pepto Bismol, Midol, Maalox, Tums, Benadryl, et.) at student's request. I understand the BISD personnel will protect my child and not administer medication if this form is not completed.

List "over'the-counter" medication NOT to given: _____

List drug or food allergies: _____

List medical conditions (asthma, illnesses, surgeries, etc.) _____

_____

Doctor's Name (print): _____ Phone _____

Permission to Administer Prescription Medications:
I request that a Bryan ISD representative administers the medication listed below to my child according to the physician's instructions. I agree to furnish an adequate amount of medication in the original container. I understand the BISD representatives will protect my child and not administer medication if this form is not completed or the medication is not furnished as required. Signing this form when no prescriptions are present allows for dispensing of a prescription drug at a later date if necessary (ie: band trips, short term illness etc.)

List all prescription medications and dosages: _____

_____

Time to be Administered: _____ Do not administer after this date: _____

Side Effects to report to Doctor: _____

Release:

I, _____, release Bryan ISD designated personnel from responsibility of wrongdoing regarding medication approval stipulated on this form.

Parent Signature: _____ Date: _____

Parent Phone Number: _____ Parent Cell Number: _____