OAKTON HIGH SCHOOL

Marching Cougars

REGISTRATION 2023-24

PART B: MB FORMS PACKET 23-24

Forms due **May 15**

Summer camp fee due **July 31**

Course fee due **August 31**

Questions? Contact forms@oaktonbands.org

Download, print and complete all relevant forms.

NOTE: Only Color Guard students need the VHSL Physical, Concussion Protocol and Guard Commitment forms.

OAKTON HIGH SCHOOL MARCHING BAND - COMMITMENT FORM

A parent signature on this form commits the student to participate in the 2023-24 Oakton High School Marching Band

In order to design and prepare the marching field show, the Band Director must know how many students will be participating in Marching Band. Parents whose students will be joining the Marching Band must register and upload all the forms for Marching Band by May 15. Marching Band course fees ($200) are due in August and Marching Band Summer Camp Activity fees ($225) are due by the start of camp on July 31.

TIME COMMITMENT FOR MARCHING BAND

- **Marching Practices** – Take place at Oakton High School during the month of August and after school in September and October (please see schedule in packet and online at oaktonbands.org). Color Guard practices will be held at other times, based on coach availability.
- **Football Games** – Perform at all home football games.
- **Marching Band Competitions** – Up to five Saturdays throughout September and October.
- **Family Volunteer Hours** - Four (4) or more volunteer hours per family are requested over the course of the school year.

FINANCIAL COMMITMENT FOR MARCHING BAND

- Marching Band Student Course Fee, Available on MySchoolBucks, DUE no later than August 31: **$200.00 – for all marching band students.**
- Summer Marching Band Camp Activity Fee, Available on MySchoolBucks, DUE 7/31: **$225.00 – for all marching band students participating in summer band camp.**
- **You may pay the Marching Band Course and Activity Fees via MySchoolBucks or check.** These fees will be available to pay in your student's MySchoolBucks account. We will notify you when the payment links are available.
- **Important:** Oakton High School will make every effort to refund parents dependent on the date of request and the availability of non-committed funds.

_____**I understand the time commitment associated with Oakton HS Marching Band.** (Please initial).

_____**I understand the Marching Band Course Fee is due August 31** and the **Marching Band Summer Band Camp Activity Fee is due July 31st.** (Please initial)

I intend to pay Marching Band fees by (check one):

_____MySchoolBucks.com _____Check payable to OHS

_____Our family cannot make payment on these fees at this time, please contact me about payment planning and/or need-based aid provided by the Band Boosters of Oakton High School. *Note,* This information is shared only with the Director, the FCPS employee in charge of forms and the BBOHS Treasurer.

Want to help with need-based aid for our students? Make a donation at: oaktonbands.org

_____ _____

Parent Name (printed) Student Name (printed)

_____ _____

Parent Signature Parent Email

Student's Name: _____

Photo Release Opt Out Form

You have the right to choose whether your student's photograph is published or not. The band posts photos on the band's password protected photo sharing site, and typically a photo of the entire band appears on the website's open home page. Student names or other identifying information are not posted with the photographs. If you want to prohibit the publication of photographs of your student in band media, put an X and sign below. **You do not need to return this form if you allow your student's photograph to be published.**

( ) Do not publish photographs of my student

_____ _____

Parent/Guardian Signature Date

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FIELD TRIP DRIVER'S LICENSE AND VEHICLE INSURANCE INFORMATION

(required when transporting students on field trips in personal or leased vehicles)

Information on the driver and the driver's liability insurance is required for all personal and leased vehicles used to transport students (not applicable for school bus or commercial bus drivers or vehicles). This is an official FCPS document. Any falsification or misrepresentation may lead to disciplinary action for FCPS Staff or liability exposure for other drivers.

FIELD TRIP PLAN

(to be completed by the trip organizer)

Specific Trip	Repeated Trip
Date	Explain
Destination	
Purpose	

DRIVER AND INSURANCE INFORMATION

PART I. DRIVER

Name

☐ Student ☐ Parent ☐ Teacher or Staff Member (Part II required) ☐ Other

Operator License Number	State	Expiration Date

☐ I certify that I have a valid driver's license as indicated

I certify that the vehicle I will use for this field trip:

☐ is designed and manufactured to transport fewer than ten passengers

☐ meets Federal Motor Vehicle Safety Standards and state standards applicable to passenger car occupant protection standards (at the time the vehicle was manufactured)

☐ has a certified seat and seat belt for each passenger (owner- or dealer-installed seats and/or seat belts are not certified)

Driver Signature _____ Date _____

PART II. FCPS STAFF ONLY

☐ I understand and acknowledge that the validity of my license and my driving record may be reviewed by FCPS Human Resources

☐ I have taken the online defensive driving tutorial offered by SafeSchools ™ https://fairfax-va.safeschools.com/login

PART III. INSURANCE

Owner or Lessee of Insured Vehicle

Insurer

Vehicle Make Model

Owner or Lessee Signature _____ Date _____

SCHOOL PRINCIPAL APPROVAL

Principal Signature _____ Date _____

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor :	Bus # (AM):	Bus # (PM):

☐ Student has medical alert information on file. See page 2 for details.

Student Cell _____

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the enrolling parent. The enrolling parent is the natural or adoptive parent or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Enrolling Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Self | ☐ Resides with | Language: | E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: | ☐ Resides with | Language: | E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: | ☐ Resides with | Language: | E-mail:

Other Parent Last: First: Middle: Telephone Home:

Number: Street: Apt.#: Work:

City: State: Zip: Cell:

Relationship: | ☐ Resides with | Language: | E-mail:

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

Name of Person	Relationship	Language	Telephone

* Please remember to sign page 2.

EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:

School Name:	ID No.:	Teacher or Counselor:	Bus # (AM):	Bus # (PM):

Siblings attending the same school (complete if applicable).

Name(s): _____

Name(s): _____

Primary Internet access in the home for this student is

☐ Cellular ☐ Broadband ☐ Other ☐ None ☐ Declined

Do you have a device for this student to use that meets their educational needs? ☐ Yes ☐ No ☐ Declined

CURRENT HEALTH CONDITIONS

Below check any current health condition(s) that EMS or an emergency room physician should know about health of your student. **Also complete and submit Health Information form SS/SE-71 if your child has a health condition(s) that require(s) attention during the school day. See below for medical alert information currently on file.**

☐ allergies (be specific)

- ☐ foods _____
- ☐ medicines _____
- ☐ bee sting or insect bite _____
- ☐ other _____

☐ asthma

☐ cancer

☐ diabetes

☐ hearing problems ☐ hearing aid(s)

☐ heart problems (be specific) _____

☐ hemophilia ☐ sickle cell anemia

☐ physical disability (be specific)

_____

☐ respiratory (be specific)

_____

☐ seizures

☐ vision problems (be specific) _____

- ☐ glasses ☐ contacts

☐ other (be specific)

_____

_____

List all medications and dosages your child receives on a continual basis:

_____

_____

_____

MEDICAL ALERT INFORMATION ON FILE

PHYSICIAN INFORMATION

My child's medical care is provided by: _____ _____
(name of doctor, clinic, or HMO) (telephone)

Does your child have health insurance? ☐ Yes ☐ No

If yes, medical coverage is provided by: _____ _____
(health insurance company, assistance program, HMO, etc.) (telephone)

First aid and emergency treatment will be provided to students in accordance with the current version of FCPS Regulation 2102 or in accordance with the student's individualized health plan.

ENROLLING PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____

Parent Information About the Emergency Care Information Form

What is the Emergency Care Information form used for?
School staff rely on the Emergency Care Information form to provide them with information needed to (1) contact a parent or other responsible adult in the event of an emergency concerning the student; (2) assist school staff or emergency medical services in the event the student requires medical services for illness or injury; (3) respond to requests to release of the student during the school day in nonemergency situations.

Who is responsible for completing the Emergency Care Information form?
This form should be completed by the enrolling parent. The enrolling parent is the natural parent, adoptive or legal guardian with whom the student lives the preponderance of the school week and who enrolled the student in school.

Who else should be listed in the Parent/Guardian Contact Information section of the form?
The Parent/Guardian Contact Information section has space for a student's other natural or adoptive parent or legal guardian to be listed. A parent's contact information should be listed in the second box if the parent shares legal custody of the child with the enrolling parent. School staff will share information about the student and will release the student to a parent who has legal custody of the child. A stepparent that resides with the child may also be listed in the Parent/ Guardian Contact Information section of the form.

Who should be listed in the Other Contact Information section of the form?
It is very important that school staff have contact information for at least two responsible adults who can be contacted in the event of an emergency when the parents cannot be reached. Other adult family members or friends should be listed in the Other Contact Information section of the form.

Please also note that school staff will allow any person you list on this form in the Other Contact Information section to pick up the child from school during the school day in both emergency and nonemergency situations.

In the event of an emergency, who will the school notify?
In the event of an emergency, school staff members will attempt to contact the enrolling parent first. If the enrolling parent cannot be reached, school staff will then attempt to reach the parent/guardian, if any. If neither the enrolling nor other parent/guardian listed can be reached, school staff shall contact the people listed in the Other Contact Information section on the Emergency Care Information form. Once a parent or designated contact is reached, staff will provide him or her with information about the student and the emergency situation and will release the student to him or her, as appropriate.

A noncustodial parent may be provided with information about the child, but staff will not release the student to him or her without the written consent of the custodial parent (Regulation 2240, III.B, and IV.F).

What should I do if I need to update the information on this form?
It is extremely important that school staff have the most up to date and accurate information about your child. The enrolling parent may update information on this form at any time by either contacting the school or accessing weCare@school in the FCPS 24-7 website (fcps.blackboard.com).

Where can I find more information about FCPS's procedures regarding the emergency care information form and first aid and emergency treatment for students?
Please refer to FCPS Regulation 2240, Parent Participation and Decision-making and FCPS Regulation 2102, First Aid, Emergency Treatment, and Administration of Medication for Students for additional information.

How do I change the phone number used for attendance and non-emergency calls?
Changes to the phone number used for attendance and non-emergency calls can only be made by contacting your child's school directly and specifying that you wish to have the student home phone number changed.

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HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her school day

This form is necessary to inform the Public Health Nurse (PHN) of your child's health status and to plan for health needs that may impact his/her school day. Information is only shared with required school staff as needed. Information provided on this form is protected by the Family Educational Rights and Privacy Act (FERPA) as part of the student's educational record and is securely stored in the health room. For any changes to your student's health condition during the school year or questions regarding this form, please contact the PHN through the health room at your child's school. Contact your child's school front office staff and ask to be connected with the health room.

Section A: Demographics

Student Name: Last	First	Middle	Date of Birth

School Year	School Name	Grade	Teacher	Gender: ☐ Male ☐ Female

Parent/Legal Guardian Name	Home Phone Number	Cell Phone Number	Work Phone Number
Parent/Legal Guardian Name	Home Phone Number	Cell Phone Number	Work Phone Number

Section B: Life Threatening Health Conditions

Does your child have a potentially life threatening health condition to include any of the following?

☐ Diabetes, Type 1 ☐ Seizures requiring rescue medication ☐ Allergy requiring epinephrine ☐ Severe Asthma

Section C: Current Health Conditions

Condition	Check if Yes	Comment
ADD/ADHD		_____ **Provider Diagnosed:** ☐ Yes ☐ No **Under Treatment:** ☐ Yes ☐ No
Allergies		**NOTE: Medication allergies are listed ONLY on Emergency Care Form**
• **Food**		Foods_____ Epinephrine ☐ Yes ☐ No If Yes, Date received _____
• **Food Intolerance**		Foods_____ Gastrointestinal/Digestive Distress ☐ Yes ☐ No Dietary Restriction/Preference ☐ Yes ☐ No
• **Bee Sting-** symptoms ***other*** than local redness/swelling		Epinephrine ☐ Yes ☐ No If Yes, Date received _____
• **Latex**		
Anxiety		Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Blood Disorder		
Cancer		Currently Immunocompromised ☐ Yes ☐ No
Dental/Oral Health Condition		
Depression		Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Diabetes		Method of Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump
Eating Disorders		Provider Diagnosed ☐ Yes ☐ No Under Treatment ☐ Yes ☐ No
Heart		
Kidney/Urinary Tract Disorders		
Migraines		

(OVER)

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HEALTH INFORMATION

Complete this form annually to inform us about your student's health condition that affects his or her school day

Last Name _____ **First Name** _____ **Date of Birth** _____

Section C: Current Health Conditions Continued

Condition	Check if Yes	Comment
Muscle/Bone/Joint		
Respiratory • **Asthma**		**Triggers:** ☐ **Exercise** ☐ **Environmental** ☐ **Other** _____ **Number of Emergency Room (ER) Visits in the last calendar year:**
• **Cystic Fibrosis**		
• **Lung Disease (other than Asthma)**		**Type** _____ **Date of last episode** _____
Seizure/Neurological		
Skin Condition		☐ **Eczema** ☐ **Other** _____
Stomach/Bowels (IBS, Crohn's etc.)		
Other Health Concerns		
Vision Conditions:		☐ **Contacts/Glasses** ☐ **Non-correctable** ☐ **Other** _____
Hearing Conditions:		☐ **Hearing Aid(s)** ☐ **Other** _____

Section D. Health Procedures

If your child has a health condition, does your child require any health procedures or need any special equipment during the school day?

☐ Yes ☐ No If you answered Yes, please describe _____

Parent or guardian is responsible for providing the school with any medication, special food, equipment that the student may require during the day. Medication, Procedure Authorization, and Physical Education (PE) forms may be found at https://www.fcps.edu/registration/forms or obtained in the school Health Room.

Parental Consent: I agree to allow my child's healthcare provider(s) to discuss information contained in this form with FCPS staff and Public Health Nurse. ☐ Yes ☐ No

_____ _____
Healthcare Provider Name Healthcare Provider Phone

_____ _____ _____
Parent/Guardian Name (Print or Type) Parent/Guardian Signature Date

Public Health Nurse Use Only Below this Line

☐ HIF Reviewed ☐ Follow Protocol (SH Care Emerg.-Temp. Care Guidelines) ☐ Health Conditions List (Medical Flag) ☐ Action Plan/Health Plan or Procedure

Notes

_____ _____ _____
Public Health Nurse Name Public Health Nurse Signature Date

Oakton High School Bands

Over-the-Counter Medications

Student's Name: _____

I give permission for my child to take (use) any of the over-the-counter medications checked below for simple headaches, cramps, upset stomach, sore throat, coughs, minor injuries, or tooth pain. These medications will be given as needed, not on a regular basis. Please check all that apply:

____ Acetaminophen (Tylenol)

____ Pepto-Bismol

____ Benadryl

____ Dramamine

____ Insect Repellant

____ Hydrocortisone Cream

____ Ibuprofen (Advil/Motrin)

____ Antibiotic Ointment

____ Aloe Vera (Sunburn Relief)

____ Imodium

____ Sudafed

____ Sunscreen

____ All of the above

_____ _____

Parent/Guardian Signature Date

This permission form is only for over-the-counter medications. The regular FCPS form is still required for prescription medications. If other over-the-counter medications are required by the student during the marching season or on trips, the medications must be provided by the parent/guardian with specific dosage instructions, AND a medical authorization form must be sent in, SIGNED by the parent, along with the medication.

Oakton High School Bands

Medical Disclosure to Parent Chaperones

Only FCPS employees will have access to the FCPS medical forms submitted in this packet, and the forms will only be accessed in the event of an emergency. With this form, you provide important information to parents who chaperone your child on band trips.

Student's Name: _____

Allergies to medication: _____

Allergies to food: _____

Other allergies: _____

Pre-existing medical conditions: _____

_____

_____ _____

Parent/Guardian Signature Date

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MEDICATION AUTHORIZATION

Release and Indemnification Agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE **PLEASE USE A SEPARATE FORM FOR EACH MEDICATION**

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby request Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided FCPS, FCHD, and SACC staff members comply with the physician, parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required.

Has the student taken this medication before? ☐ Yes ☐ No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)
First dose was given: Date _____ Time _____

Student Name: Last	First	Middle

Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse, or school health aide shall administer medication or treatment, as an exception under School Board policy, unless the principal or his or her designee has personally reviewed all the required clearances. I give permission to contact the below named physician/provider to clarify information provided on the authorization should the need arise.

_____ _____ _____
Parent or Guardian Signature Daytime Telephone Date

PART II PARENT OR GUARDIAN TO COMPLETE AND SIGN FOR OVER-THE-COUNTER MEDICATION PER MANUFACTURER'S RECOMMENDATION FOR RELIEF OF SYMPTOMS FOR HEADACHE, MUSCLE ACHE, ORTHODONTIC PAIN, OR MENSTRUAL CRAMPS AND FOR ANTIBIOTIC AND ANTIVIRAL MEDICATION. PHYSICIAN MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS.

The Fairfax County Health Department and Fairfax County Public Schools discourage the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and overnight field trips and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

Diagnosis

Medication

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.

Dosage to be given at school or SACC, (e.g. mg, ml, or cc)	Time(s) or interval between times to be given

Effective date _____
☐ Current School Year ☐ From _____ To _____

If the student is taking more than one medication at school, list sequence in which medications are to be taken _____

_____ _____ _____ _____
Physician Name (Print or Type) Physician Signature Telephone or Fax Date

_____ _____ _____ _____
Parent or Guardian Name (Print or Type) Parent or Guardian Signature Telephone Date
(Not required if physician signs)

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate

☐ Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)
☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent.
(Within one week after expiration of the physician order or on the last day of school.)

_____ _____
Principal or Designee Signature Date

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. Medications should be taken at home whenever possible so that the student will not lose valuable classroom time or have a shortened lunch period. Any medication taken in school or SACC must have a parent or guardian-signed authorization; some medications also require physician orders. Medication must be kept in the school health room or other school-approved location during the school day. **The parent or guardian must transport medications to and from school, except a high school student may carry an over-the-counter medication to and from the school health room.**

2. No medication will be accepted by school or SACC personnel without receipt of completed and appropriate medication forms.

3. A physician may use office stationery or a prescription pad in lieu of completing part II. Include the following information written in lay language with no abbreviations:

   - Name of student
   - Date of birth
   - Reason for medication or diagnosis
   - Name of medication
   - Exact dosage to be taken in school, (e.g. milligrams per tablet, milligrams per ml/cc) as applicable
   - Time to take medication and frequency or exact time interval dosage is to be administered
   - Sequence in which the medications should be taken in cases where more than one medication is prescribed
   - If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again. ("Repeat as necessary" is unacceptable.)
   - Duration of medication order or effective dates
   - Physician's signature
   - Date

4. All prescription medications, including physician's prescription drug samples, **must** be in their original containers and labeled by a physician or pharmacist. An over-the-counter medication **must** be in the original container with the name of the medication visible. The parent or guardian must label the original container with the following:

   - Name of student
   - Exact dosage to be taken in school (e.g. milligrams per tablet, milligrams per ml/cc)
   - Frequency or time interval dosage is to be administered

5. **The first dose of any new medication must be given at home.**

6. The parent or guardian is responsible for submitting a new form to the school and to SACC at the start of the school year and each time there is a change in the dosage or in the time at which medication is to be taken.

7. Medication kept in the school will be stored in a locked area accessible only to authorized personnel.

8. Within one week after expiration of the effective date on the physician order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

9. The student is to come to the school health room, or to a predetermined location, at the prescribed time to receive medication. Parents should develop a plan with the student to ensure that the student goes to the school health room at the appropriate time. **Medication can be given no more than one half hour before or after the prescribed time.**

10. The Fairfax County Health Department, Fairfax County Public Schools, and Fairfax County School Age Child Care do not assume responsibility for authorized medication taken independently by the student.

11. In no case may any health, school, or SACC staff member administer any medication outside the framework of the procedures outlined here and/or in FCPS regulations.

12. The parent/guardian must provide a supply of medication to FCPS and SACC for medication required to be administered during the school day and in SACC.

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INHALER AUTHORIZATION

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to permit the student identified below to use an inhaler in school as prescribed. I agree to release, indemnify, and hold harmless FCPS, FCHD, SACC, and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student with the inhaler, provided FCPS, FCHD, and SACC personnel are following physician orders in part II.

Has the student taken this medication before? ☐ Yes ☐ No (If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)

First dose was given: Date _____ Time _____

Student Name: Last	First	Middle

Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse, or school health aide shall administer medication or treatment, as an exception under School Board policy, unless all the required clearances have been personally reviewed by the principal or his or her designee. I give permission to contact the below named physician/provider to clarify information provided on the inhaler authorization form should the need arise.

_____ _____ _____
Parent or Guardian Signature | Daytime Telephone | Date

PART II PHYSICIAN TO COMPLETE INFORMATION SHOULD BE WRITTEN IN LAY LANGUAGE WITH NO ABBREVIATIONS

Diagnosis	List triggers
Medication	Dosage to be given at school or SACC
Symptoms or activity for which medication is ordered	Time(s) medication is given
Effective date ☐ Current School Year ☐ From _____ To _____	Time interval for repeating dosage

If the student is taking more than one medication at school, list the sequence in which medications are to be taken

Check the appropriate box:

I believe that this student has received adequate information on how and when to use an inhaler and that he or she can use it properly.

☐ The student is to carry an inhaler during school or SACC hours with the principal's knowledge. (An additional inhaler, to be used as backup, may be kept in the school health room or other approved school location.)

☐ The inhaler will be kept in the school health room or other approved location (specify) _____

_____	_____	_____	_____
Physician Name (Print or Type)	Physician Signature	Telephone or Fax	Date
_____	_____	_____	_____
Parent or Guardian Name (Print or Type) (Required if student carries inhaler)	Parent or Guardian Signature	Telephone	Date

_____ _____
Student Signature
(Required if student carries inhaler) | Date

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent.
(Within one week after expiration of the physician order or on the last day of school.)

_____ _____
Principal or Principal Designee Signature | Date

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

PARENT INFORMATION ABOUT INHALER PROCEDURES

1. Nonessential medication will not be permitted in school during school hours or during school-sponsored activities or SACC. Any medication taken in school or at SACC must have the parent or guardian-signed authorization and physician order if required by regulation.

2. The parent or guardian is responsible for obtaining the physician's statement in part II.

3. A physician may use office stationery or a prescription pad in lieu of completing part II. Include the following information written in lay language with no abbreviations:
   - Name of student
   - Date of order
   - Duration of medication order and effective dates
   - Reason for medication or diagnosis
   - Name of medication
   - Exact dosage to be taken in school
   - Time to take medication and frequency or exact time interval dosage is to be administered
   - If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again. ("Repeat as necessary" is unacceptable.)
   - Symptoms, other medications the student is taking
   - Statement that the student may self-administer
   - Physician's signature
   - Date

4. Physician samples must be appropriately labeled by the physician to include information requested in item 3 above.

5. The parent or guardian is responsible for submitting a new form to the school or SACC at the start of the school year and each time there is a change in the dosage or in the time at which medication is to be taken. The first dose of any new medication shall be given at home.

6. Inhaler must be hand delivered to the school health room by the parent or guardian unless approved for the student to carry during school and SACC hours.

7. Medication kept in the school will be stored in a locked area accessible only to authorized personnel unless approved for the student to carry it during school hours. If a student carries his or her own inhaler, a backup may be kept in the school health room.

8. Within one week after expiration of the effective date on the physician order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication(s) unless the student has been authorized to carry them. Medications not claimed within that period will be destroyed.

9. In no case may any health worker or school or SACC staff member administer any medication outside the framework of the procedures outlined here and/or in FCPS regulation.

10. The parent/guardian must provide a supply of medication to FCPS and SACC for medication required to be administered during the school day and in SACC.

EPINEPHRINE AUTHORIZATION

FAIRFAX COUNTY PUBLIC SCHOOLS

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I PARENT OR GUARDIAN TO COMPLETE

I hereby authorize Fairfax County Public Schools (FCPS), Fairfax County Health Department (FCHD), and School Age Child Care (SACC) personnel to administer epinephrine injection(s) as directed by the physician (part II). I agree to release, indemnify, and hold harmless FCPS, FCHD, and SACC and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for administering the injection, provided they follow the physician's order (part II.) I am aware that the injection may be administered by a specifically trained nonhealth professional. I have read the procedures outlined on the back of this form and assume responsibility as required.

I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

Student Name (Last, First, Middle)			
Date of Birth	School Name	School Year	Grade

No School Board employee, public health nurse, or clinic room aide shall administer medication or treatment, as an exception under School Board policy, unless all the required clearances have been personally reviewed by the principal or his or her designee.

I give permission to contact the below named physician/provider to clarify information provided on the authorization should the need arise.

Parent or Guardian Signature _____ *Daytime Telephone* _____ *Date* _____

PART II PHYSICIAN TO COMPLETE

Emergency injections are usually administered in FCPS or SACC by nonhealth professionals. These persons are trained by the school public health nurse to administer the injection. For this reason, only premeasured doses of epinephrine may be given. It should be noted that these staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.

The following injection will be given immediately after report of exposure to _____
Indicate specific allergen(s) or unknown

Route of exposure: ☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Insect sting or bite

OR

The following symptoms

☐ Sudden difficulty breathing, wheezing
☐ Swelling of the throat, lips,tongue, tightness/change of voice, difficulty swallowing.
☐ Tingling sensation, itching, or metallic taste in mouth
☐ Feeling of apprehension, agitiation
☐ Vomiting PLUS one of the above symptom
☐ Other _____

Check the appropriate boxes:

☐ Give the premeasured dose of 0.3mg epinephrine 1:1000 aqueous solution (0.3cc) by autoinjection.
☐ Repeat dose in ☐ 5 minutes ☐ 10 minutes ☐ 15 minutes if EMS has not arrived. (Two premeasured doses will be needed in school.)

☐ Give the premeasured dose of 0.15mg epinephrine 1:2000 aqueous solution (0.3cc) by autoinjection.
☐ Repeat dose in ☐ 5 minutes ☐ 10 minutes ☐ 15 minutes if EMS has not arrived. (Two premeasured doses will be needed in school.)

Check the appropriate box:

I believe that this student has received adequate information on how and when to use epinephrine.

☐ The student is to carry an epinephrine autoinjector during school hours with the principal's knowledge. One additional dose, to be used as backup, should be kept in health room or other approved school location.
☐ The student can use the epinephrine autoinjector properly in an emergency. One additional dose, to be used as backup, should be kept in health room or other approved school location.
☐ The epinephrine autoinjector will be kept in the school health room.

Effective date: ☐ Current school year ☐ From _____ To _____

Physician Name (Print or Type) _____ *Physician Signature* _____ *Telephone or Fax* _____ *Date* _____

Parent or Guardian Name (Print or Type) _____ *Parent or Guardian Signature* _____ *Telephone* _____ *Date* _____
(Required if student carries epinephrine)

Student Signature _____ *Date* _____
(Required if student carries epinephrine)

PART III PRINCIPAL OR PRINCIPAL DESIGNEE TO COMPLETE

Check √ as appropriate:

☐ Parts I and II above are complete including signatures. (It is acceptable if all items in part II are written on the physician's stationery or a prescription pad.)

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent.
(Within one week after expiration of the physician order or on the last day of school.)

Principal or Principal Designee Signature _____ *Date* _____

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent, guardian, or eligible student.

SS/SE-64 11/15 Distribution: Original-School, Copy-Parent or Guardian

PARENT INFORMATION ABOUT EPINEPHRINE PROCEDURES

1. Epinephrine may be given in school, during school-sponsored activities, or at SACC only with both physician and parent or guardian-signed authorization.

2. This form must be on file in the health room or in an other approved location. The parent or guardian is responsible for obtaining the physician's statement in part II. For a student who attends SACC, a copy of the medication form must be on file with SACC.
3. A new form must be submitted to the school each school year and whenever there is a change in the dosage or a change in the conditions under which epinephrine is to be injected.

4. A physician may use office stationery or a prescription pad in lieu of completing part II. Information necessary includes:

    - Name of student
    - Specific allergen(s) for which epinephrine is being prescribed
    - Route of exposure (e.g., ingestion, skin contact, inhalation, or insect sting or bite)
    - Brand name of medication
    - Amount of premeasured epinephrine
    - Time for repeated dose if deemed necessary
    - Duration of medication order and effective dates
    - Physician signature
    - Date

5. Only premeasured doses of epinephrine may be given by FCPS, FCHD, and SACC staff members.

6. Medication must be properly labeled by a pharmacist. If a physician's orders include a repeat of the epinephrine injection, then the parent or guardian must supply the school with two epinephrine autoinjectors. For a student who carries his or her own epinephrine autoinjector, the parent must supply the school with a back up that is stored in the health room or other approved location. Expiration date must be clearly indicated on the pharmacy label or autoinjector. The parent must provide a replacement epinephrine autoinjector when notified that the current autoinjector has expired or has been administered.

7. Epinephrine must be hand-delivered to the school health room by the parent or guardian unless approved for the student to carry during school and SACC hours.

8. Unless the student has been authorized to carry epinephrine, the parent or guardian is to collect any unused epinephrine within one week after the end of expiration of the order or on the last day of school. Epinephrine not claimed within that period shall be destroyed.

I verify that I have received, reviewed and understand the information contained in the FCPS Concussion Education Presentation

PRINT FORM

Student name (print) _____

School _____ Student ID# _____

Student Signature _____ Date_____

Parent/Guardian

Signature _____ Date_____

Please return this page to the Activities Office along with your physical!

Oakton High School Fall Color Guard Agreement
Handbook is located at: oaktonbands.org/guard

Student Agreement

I have read and understand the information presented in the OHS Fall Color Guard Handbook located on the OaktonBands.org website. By signing below, I agree to abide by the guidelines listed herein. I acknowledge that by signing below, I am making a commitment, not only to myself, but to the other members of the color guard. My fellow members will depend on me to attend all rehearsals and performances, be prepared for rehearsal, and meet all the other obligations outlined in the handbook. I understand that if I am unable to or choose to work or act in a contrary manner to the standards and expectations listed in the handbook, appropriate disciplinary action will be taken, which may include my being removed from the team.

Print Student Name Signature Date

Parent/Guardian Agreement

I have read and understand the information presented in the OHS Fall Color Guard Handbook. By signing below, I agree to support the guidelines listed herein. I acknowledge that if my student does not follow these guidelines he or she will be subject to appropriate disciplinary action which may include being removed from the team. I also agree to pay the full cost outlined in the pay-to-play costs section of the handbook as determined by the Oakton High School Band Boosters. I understand active and engaged parents are part of the success of the program.

Print Parent/Guardian Name Signature Date

Special Notes:

- If you do not return a signed copy of this form with both your signature and your parent/guardian's signature, you will not be allowed to participate in rehearsal.

VIRGINIA HIGH SCHOOL LEAGUE, INC.

1642 State Farm Blvd., Charlottesville, Va. 22911

ATHLETIC PARTICIPATION/PARENTAL CONSENT/PHYSICAL EXAMINATION FORM

Separate signed form is required for each school year **MAY 1** of the current year through **JUNE 30** of the succeeding year.

For school year_____ **PART I- ATHLETIC PARTICIPATION** Male___

(To be filled in and signed by the student) Female___

PRINT CLEARLY

Name _____ Student ID#_____

(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Home Address of Parents _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

This is my _____ semester in _____ High School, and my _____ semester since first entering the ninth grade. Last semester I attended _____ School and passed _____ credit subjects, and I am taking _____ credit subjects this semester. I have read the condensed individual eligibility rules of the Virginia High School League that appear below and believe I am eligible to represent my present high school in athletics.

INDIVIDUALIZED ELIGIBILITY RULES

To be eligible to represent your school in any VHSL interscholastic athletic contest, you:

- Must be a regular bona fide student in good standing of the school you represent.
- Must be enrolled in the last four years of high school. (Eighth-grade students may be eligible for junior varsity)
- Must have enrolled not later than the fifteenth day of the current semester.
- For the first semester must be currently enrolled in not fewer than five subjects, or their equivalent, offered for credit and which may be used for graduation and have passed five subjects, or their equivalent, offered for credit and which may be used for graduation the immediately preceding year or the immediately preceding semester for schools that certify credits on a semester basis. (Check with your principal for equivalent requirements.) **May not repeat courses for eligibility purposes for which credit has been previously awarded.**
- For the second semester must be currently enrolled in not fewer than five subjects, or their equivalent, offered for credit and which may be used for graduation and have passed five subjects, or their equivalent, offered for credit and which may be used for graduation the immediately preceding semester. (Check with your principal for equivalent requirements.)
- Must sit out all VHSL competition for 365 consecutive calendar days following a school transfer unless the transfer corresponded with a family move. (Check with your principal for exceptions.)
- Must not have reached your nineteenth birthday on or before the first day of August of the current school year.
- Must not, after entering ninth grade for the first time, have been enrolled in or been eligible for enrollment in high school more than eight consecutive semesters.
- Must have submitted to your principal before any kind of participation, including tryouts or practice as a member of any school athletic or cheerleading team, an Athletic Participation/Parent Consent/Physical Examination Form, completely filled in and properly signed attesting that you have been examined during this school year and found to be physically fit for competition and that your parents' consent to your participation.
- Must not be in violation of VHSL Amateur, Awards, All Star or College Team Rules. (Check with your principal for clarification about cheerleading.)

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above-listed minimum standards, but also all other standards set by your League, district and school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, **check with your principal for interpretations and exceptions provided under League rules.** Meeting the intent and spirit of League standards will prevent you, your team, school and community from being penalized. Additionally, I give my consent and approval for my picture and name to be printed in any high school or VHSL athletic program, publication or video.

LOCAL SCHOOL DIVISIONS AND VHSL DISTRICTS MAY REQUIRE ADDITIONAL STANDARDS TO THOSE LISTED ABOVE.

→Student Signature:_____ Date:_____

PROVIDING FALSE INFORMATION WILL RESULT IN INELIGIBILITY FOR ONE YEAR.

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

PART II- MEDICAL HISTORY (Explain "YES" answers below)

This form must be complete and signed, prior to the physical examination, for review by examining practitioner.
Explain "YES" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical conditions? If so, please identify: ☐ Asthma ☐Anemia ☐Diabetes ☐ Infections ☐Other: _____	☐	☐
4. Are you currently taking any medications or supplements on a daily basis?	☐	☐
5. Do you have allergies to any medications?	☐	☐
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	☐	☐
7. Have you ever spent the night in the hospital? If yes, why? _____	☐	☐
8. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?	☐	☐
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.	☐	☐
13. Has a doctor ever told you that you have any heart problems, including: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other _____	☐	☐
14. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
15. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
16. Does anyone in your family have a heart problem?	☐	☐
17. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?	☐	☐
18. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐
BONE AND JOINT QUESTIONS	**YES**	**NO**
20. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
21. Do you currently have a bone, muscle or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**YES**	**NO**
22. Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐

MEDICAL QUESTIONS CONTINUED	YES	NO
24. Have you had mononucleosis (mono) within the last month?	☐	☐
25. Are you missing a kidney, eye, testicle, spleen or other internal organ?	☐	☐
26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
27. Have you ever become ill while exercising in the heat?	☐	☐
28. When exercising in the heat, do you have severe muscle cramps?	☐	☐
29. Do you have headaches with exercise?	☐	☐
30. Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs AFTER being hit or falling?	☐	☐
31. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
32. Have you had any other blood disorders?	☐	☐
33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?	☐	☐
34. Have you had or do you have any problems with your eyes or vision?	☐	☐
35. Do you wear glasses or contacts?	☐	☐
36. Do you wear protective eyewear like goggles or a face shield?	☐	☐
37. Do you worry about your weight?	☐	☐
38. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
39. Do you limit or carefully control what you eat?	☐	☐
40. Have you ever had an eating disorder?	☐	☐
41. Are you on a special diet or do you avoid certain types of foods or food groups?		
42. Allergies to food or stinging insects?	☐	☐
43. Have you ever had a COVID-19 diagnosis? Date:	☐	☐
44. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____		
FEMALES ONLY	**YES**	**NO**
45. Have you ever had a menstrual period?	☐	☐
46. Age when you had your first menstrual period: _____		
47. Number of periods in the last 12 months: _____		
48. When was your most recent menstrual period? _____		

EXPLAIN "YES" ANSWERS BELOW

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List medications and nutritional supplements you are currently taking here:

→ Parent/Guardian Signature: _____ Date: _____ → Athlete's Signature: _____

PART III- PHYSICAL EXAMINATION

(Physical examination form is required each school year dated after *May 1* of the preceding school year and is good through June 30 of the current school year)**

NAME_____ **DATE OF BIRTH**_____ **SCHOOL**_____

Height	Weight	☐ Male	☐ Female
BP /	Resting pulse	Vision R 20/ L 20/	Corrected ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)		
Eyes/ears/nose/throat (Pupils equal, hearing)		
Lymph nodes		
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (i.e. Double leg squat, single leg squat, box drop or step drop test)		
Emergency medications required on-site: ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other:		
COMMENTS:		

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION**

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:**

_____

☐ **MEDICALLY ELIGIBLE <u>ONLY</u> FOR THE FOLLOWING SPORTS:**_____

Reason:_____

☐ **<u>NOT</u> MEDICALLY ELIGIBLE PENDING FURTHER EVALUATION OF:** _____

☐ **<u>NOT</u> MEDICALLY ELIGIBLE FOR ANY SPORTS**

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II- Medical History.

→ **PRACTITIONER SIGNATURE:** _____ **(MD, DO, NP or PA)+ DATE**:** _____

EXAMINER'S NAME AND DEGREE (PRINT): _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant <u>licensed to practice in the United States</u> will be accepted.

Rule 28B-1 (3) Physical Examination Rule/Transfer Student (10-90)- When an out-of-state student who has received a current physical examination elsewhere transfers to Virginia and attaches proof of that physical examination to the League form #2, the student is in compliance with physical examination requirements.

PART IV- ACKNOWLEDGEMENTS OF RISK AND INSURANCE STATEMENT

(To be completed by parent/guardian)

I give permission for _____ (name of child/ward) to participate in any of the following sports that are NOT crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacrosse, soccer, softball, swim/dive, tennis, track, volleyball, wrestling, other (identify sports): _____

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts or some other means. He/she has student medical/accident insurance available through the school (yes__ no__); has athletic participation insurance coverage through the school (yes__ no__); is insured by our family policy with:
Name of medical insurance company: _____

Policy number: _____ Name of policy holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the school to perform a pre-participation examination on my child and to provide treatment for any injury or condition resulting from participation in athletics/activities for his/her school during the school year covered by this form. I further consent to allow said physician(s) of health care provider(s) to share appropriate information concerning my child that is relevant to participation in athletics and activities with coaches and other school personnel as deemed necessary.

Additionally, I give my consent and approval for the above named student's picture and name to be printed in any high school or VHSL athletic program, publication or video.

To access quality, low-cost comprehensive health insurance through FAMIS for your child, please contact Cover Virginia by going to www.coverva.org or calling 855-242-8282.

PART V- EMERGENCY PERMISSION FORM*

(To be completed and signed by the parent/guardian)

STUDENT'S NAME: _____ GRADE: _____ AGE: _____ DOB: _____

HIGH SCHOOL: _____ CITY: _____

Please list any significant health problems that might be significant to a physician evaluating your child **in case of an emergency:**

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS, ETC: _____

_____

IS THE STUDENT CURRENTLY PRESCRIBED AN INHALER OR EPI-PEN? _____ LIST THE EMERGENCY MEDICATION: _____
IS THE STUDENT PRESENTLY TAKING ANY OTHER MEDICATION? _____ IF SO, WHAT? _____
DOES THE STUDENT WEAR CONTACT LENSES? _____ DATE OF LAST Tdap OR Td (TETANUS) SHOT: _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ High School to hospitalize, secure proper treatment for and to order the injection and/or anesthesia and/or surgery for the person named above.
DAYTIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

EVENING TIME PHONE NUMBER (WHERE TO REACH YOU IN AN EMERGENCY): _____

CELL PHONE NUMBER: _____

→ SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

RELATIONSHIP TO STUDENT: _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment in needed.

→ I CERTIFY ALL OF THE ABOVE INFORMATION IS CORRECT: _____

Parent/Guardian signature

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.