

Smithville Band Emergency/Medical Care
2009-2010

Name of Student _____
(Last) (First) (Middle)

Home Address _____ Email Address _____

Phone _____ Cell Phone _____

Where parents may be reached in case of an emergency.

Father's Name _____ Mother's Name _____

Home Phone _____ Home Phone _____

Relative or Friend contact in case parents cannot be reached.

Name _____ Phone _____

Name of Family Physician _____ Phone _____

(If unable to name a physician or pay medical services, then medical, hospital, or welfare services may be authorized.)

A. **Emergency Care:** In case of an accident or sudden illness to the above named child, and in the event I cannot be reached by telephone, I hereby authorize a representative of the **Smithville Independent School District** personnel to secure appropriate Emergency Medical Services.

B. My child is receiving medication: YES _____ NO _____

I agree to furnish an adequate amount of the medication in pharmacy container with the current prescription label listing the child's name, the drug, the doctor's name, the directions concerning dosage and the pharmacy number. I understand that **Smithville Independent School District** personnel will protect my child and not administer medication if this medication form is not completed or I do not furnish the medication as required.

I authorize a representative of the Smithville Independent School District to administer the following medication to my child during this field trip:

Copy medication instructions from the medical container.

Name of Medication	Dosage	Time Taken
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Any known allergies? Yes _____ No _____

Please list below:

Date _____
Parent or Guardian Signature: _____

** Parents and students should be aware that this form must be turned in prior to leaving or they will not attend.