

WALLED LAKE CONSOLIDATED SCHOOL DISTRICT

**EXTENDED/OVERNIGHT PERFORMING ARTS PARENT NOTICE & MEDICAL CONSENT**

*Check One:* Forensics \_\_\_ Vocal Music \_\_\_ Orchestra \_\_\_ Band X

School: WLN/WLC/WLW Department: Band (Winter Guard) Grade: \_\_\_

Teacher: Seth Williams Course: Winter Guard # of Students: 22

Destination: Frankfort, IL Phone: (734) 925-3670

Purpose of Trip: WGI Chicago Regional

Number of Days: 3 Date Leaving: 2.25.2022 Date Returning: 2.27.2022

Number of Chaperones: 10 Method of Transportation: Private Car

**LODGING INFORMATION**

Dates: 2.25.2022-2.27.2022 Facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_

*Please complete bottom portion and return no later than November 20, 2021*

**PARENT PERMISSION & MEDICAL CONSENT**

(No Verbal Permission Accepted)

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Home Phone(s) \_\_\_\_\_ Home Phone(s) \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

If unable to reach call: Name \_\_\_\_\_ Phone \_\_\_\_\_

or Name \_\_\_\_\_ Phone \_\_\_\_\_

Current Medications \_\_\_\_\_ Allergies \_\_\_\_\_

Special Concerns \_\_\_\_\_

I recognize that while on an extended field trip, medical treatment on an emergency basis may be necessary, and I further recognize that school personnel may be unable to contact me for my consent for emergency medical care. Therefore, I consent in advance to such emergency care including hospital care as may be deemed necessary under the then existing circumstances. Therefore, I provide the following information:

Insured's Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Contract No. \_\_\_\_\_ Group Number \_\_\_\_\_

I have discussed with my child the necessity of acting responsibly while on the trip and in accordance with the Student Code of Conduct. If my child violates the Student Conduct Code, I agree to pick my child up and remove him/her from this field trip.

I give my child, \_\_\_\_\_, permission to participate in the above listed field trip.  
(Print Child's Full Name)

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

***THIS FORM MUST BE IN POSSESSION OF TEACHER WHILE ON TRIP***

WALLED LAKE CONSOLIDATED SCHOOL DISTRICT

**EXTENDED/OVERNIGHT PERFORMING ARTS PARENT NOTICE & MEDICAL CONSENT**

**Check One:** Forensics \_\_\_ Vocal Music \_\_\_ Orchestra \_\_\_ Band X

School: WLN/WLC/WLW Department: Band (Winter Guard) Grade: \_\_\_\_\_

Teacher: Seth Williams Course: Winter Guard # of Students: 22

Destination: Dayton, Ohio Phone: (734)925-3670

Purpose of Trip: WGI World Championships

Number of Days: 5 Date Leaving: 4.6.2022 Date Returning: 4.10.2022

Number of Chaperones: 10 Method of Transportation: Private Car

**LODGING INFORMATION**

Dates: 4.6.2022 – 4.10.2022 Facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_

*Please complete bottom portion and return no later than November 20, 2021*

**PARENT PERMISSION & MEDICAL CONSENT**

(No Verbal Permission Accepted)

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Home Phone(s) \_\_\_\_\_ Home Phone(s) \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

If unable to reach call: Name \_\_\_\_\_ Phone \_\_\_\_\_

or Name \_\_\_\_\_ Phone \_\_\_\_\_

Current Medications \_\_\_\_\_ Allergies \_\_\_\_\_

Special Concerns \_\_\_\_\_

I recognize that while on an extended field trip, medical treatment on an emergency basis may be necessary, and I further recognize that school personnel may be unable to contact me for my consent for emergency medical care. Therefore, I consent in advance to such emergency care including hospital care as may be deemed necessary under the then existing circumstances. Therefore, I provide the following information:

Insured's Name \_\_\_\_\_ Insurance Company \_\_\_\_\_

Contract No. \_\_\_\_\_ Group Number \_\_\_\_\_

I have discussed with my child the necessity of acting responsibly while on the trip and in accordance with the Student Code of Conduct. If my child violates the Student Conduct Code, I agree to pick my child up and remove him/her from this field trip.

I give my child, \_\_\_\_\_, permission to participate in the above listed field trip.  
(Print Child's Full Name)

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

***THIS FORM MUST BE IN POSSESSION OF TEACHER WHILE ON TRIP***

**Allergy / Medical Condition & OTC Medication Permission Form  
Walled Lake Winter Guard 2021-2022 Season**

\_\_\_\_\_, has my permission to receive the "over the counter" medications, as noted below with a check mark, for the duration of the 2021-2022 Winter Guard Season.

I have listed below any known allergies, treatments, medications, and medical conditions associated with my child.

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Print Parent / Guardian Name \_\_\_\_\_ Emergency Phone \_\_\_\_\_

**Allergy / Medical Condition(s)**

- No Medical Conditions Known
- Seasonal Allergies (please list below)
- Insect Allergies
- Food Allergies (list below)
- No Known Allergies

List Daily Meds:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Any Known Medical Conditions:

\_\_\_\_\_  
\_\_\_\_\_

**OTC Medication Permission**

Check all medications your child has your permission to receive

- |  |   |
|--|---|
| <input type="checkbox"/> Tylenol (Acetaminophen)         | <input type="checkbox"/> Advil/Motrin (Ibuprofen) |
| <input type="checkbox"/> Benadryl (Diphenhydramine) oral | <input type="checkbox"/> Calamine Lotion          |
| <input type="checkbox"/> Maalox, Mylanta, or Tums        | <input type="checkbox"/> Claritin                 |
| <input type="checkbox"/> Imodium                         | <input type="checkbox"/> Sudafed                  |
| <input type="checkbox"/> Midol                           | <input type="checkbox"/> Aleve                    |

Date	Time	Medication	Dose	Reason	Initials

Administrators' Signatures: (print name and sign)

\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION TO ADMINISTER MEDICATION**

Permission Form for Prescribed Medication and Over-the-Counter Medication.  
This Authorization is Valid for the Current School Year Only.

**TO BE COMPLETED BY THE PARENT/GUARDIAN**

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Teacher/Classroom: Seth Williams / Winter Guard

I have read the policy and regulations pertaining to administration of medication. I request that (name of student) \_\_\_\_\_ receive the medication specified below at school according to standard school policy. I understand the parent is required to deliver medication to school.

\_\_\_\_\_  
Date Parent/Guardian Signature

Self Administration: High school students may self administer medication. Elementary and middle school students may self administer only emergency medications such as Epi Pens and inhalers with the approval of the parent and physician. I request that (name of student) \_\_\_\_\_ be allowed to self-administer the medication below at school according to school policy.

\_\_\_\_\_  
Date Parent/Guardian Signature

**TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:**

Name of Medication: \_\_\_\_\_

Reason for Medication (optional): \_\_\_\_\_

Form of Medication/Treatment:  Tablet/Capsule  Liquid  Inhaler  Injection  Nebulizer  
 Other \_\_\_\_\_

Instructions: (Times and dose to be given at school): \_\_\_\_\_

Start:  Date form received  Other date: \_\_\_\_\_

Stop:  End of school year  Other date/duration: \_\_\_\_\_

Restrictions and/or adverse reactions:

None anticipated  Yes. Please describe: \_\_\_\_\_

Special storage requirements:  None  Refrigerate Other: \_\_\_\_\_

This student is both capable and responsible for self-administering this medication.  
 No  Yes, Supervised  Yes, Unsupervised  
This student may carry this medication:  Yes  No

**PLEASE PRINT:**

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

**Office Use Only:**  
**Date received:** \_\_\_\_\_ **Received by:** \_\_\_\_\_  
**Administrative Approval:** \_\_\_\_\_