2022 WLP: MEDICAL FORMS

** All forms must be completed by a parent or guardian **

☐ PHYSICAL

- We must have a physical on file for the 2021/2022 school year.
- If you were in the Walled Lake Competitive Marching Band, then we already have yours.
- If not, you will need to bring a copy before the November 22nd practice.

☐ WLP FORM E-1

- Overnight Form and Medical Consent Form for WGI Regional
- Gives WLP permission to give medical care in case of emergency for overnight events.

☐ WLP FORM E-2

- Overnight Form and Medical Consent Form for WGI Championships
- Gives WLP permission to give medical care in case of emergency for overnight events.

☐ WLP FORM F

- Allergy and Medication Permission Form.
- List any known allergies or medical conditions.
- Gives WLP permission to give over the counter medicine that you indicate on the form.

☐ WLP FORM G

- Authorization to Administer Medication.
- Gives WLP permission to administer any prescribed medication during any WLP event if need be (we'd prefer this be handled by a parent/guardian though).

DUE DATE: on or before November 22nd

WLP FORM E - 1

IFCB-R FIELD TRIPS IFCB-R-13c

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 (WLP) Grade: ____

Teacher: Nick Pourcho Course: indoor drumline # of Students: 40

Destination: Dayton, OH Phone: (517) 449-4579

Purpose of Trip: WGI Dayton Regional

Number of Days: 3 Date Leaving: 3.25.2022 Date Returning: 3.27.2022

Number of Chaperones: 10 Method of Transportation: Private Car

LODGING INFORMATION

Dates: 3.25.2022-3.27.2022 Facility: _____

Address: _____ Phone: (_____

Please complete bottom portion and return no later than November 16, 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

WLP FORM E - 2

IFCB-R FIELD TRIPS IFCB-R-13c

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 (WLP) OPEN LINE Grade: ____

Teacher: Nick Pourcho Course: indoor drumline # of Students: 40

Destination: Dayton, Ohio Phone: (517) 449-4579

Purpose of Trip: WGI Percussion World Championships

Number of Days: 5 Date Leaving: 4.20.2022 Date Returning: 4.24.2022

Number of Chaperones: 15 Method of Transportation: Private Car

LODGING INFORMATION

Dates: 4.20.2022 – 4.24.2022 Facility: _____

Address: _____ Phone: (_____

Please complete bottom portion and return no later than November 16, 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

WLP FORM F

Allergy / Medical Condition & OTC Medication Permission Form
Walled Lake Percussion 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 WLP 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

_____ Tylenol (Acetaminophen)
_____ Benadryl (Diphenhydramine) oral
_____ Maalox, Mylanta, or Tums
_____ Imodium
_____ Midol
_____Advil/Motrin (Ibuprofen)
_____Calamine Lotion
_____Claritin
_____Sudafed
_____Aleve

Date	Time	Medication	Dose	Reason	Initials

Administrators' Signatures: (print name and sign)

_____ _____

_____ _____

WLP FORM G

JGFGB-R JGFGB-R-13

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: Nick Pourcho/WLP

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: _____

7/8/96 Rev. 8/21/97, 6/18/98, 3/4/04, 8/16/07