Students are ***not*** permitted to self- administer medications and should not be carrying medications with them for band events/trips.

_____
Print Student Last Name/First Name

_____
Instrument

2015 – 2016 Medication Authorization Form/Medical Permit

Information submitted on this form will only be used by the Lafayette Band Directors, staff and members of Lafayette Band Association (LBA) along with FCPS, in support of the band program at Lafayette High School.

This is a two-page form. Please be sure to complete ALL of the information on both sides before returning it. It is the parents' guardians' responsibility to provide updates to medical conditions and/or needs as they occur.

Student Name: _____ **DOB:** _____
Parent 1/Guardian Name(s): _____ **Relation**: _____
Cell: _____**Home:** _____**Work:** _____
Parent 2/Guardian Name(s): _____ **Relation**: _____
Cell: _____**Home:** _____**Work:** _____

Please list any medical concerns or past medical history of which the Chaperones/Staff should be aware:
_____
_____

Does your student take daily medications? If so, please list:
_____
_____

Any known allergies? Y / N **If yes, to what?** _____
What kind of reaction? Please explain: __
_____
Student's Physician _____ **Physician's Phone number** _____

I, the undersigned Parent/Guardian, hereby give my permission for _____ to take the OTC medications I have authorized on page two of this form in accordance with the directions explicitly described on page one for each medication. I understand that, in order for school personnel or authorized chaperones to administer any type of medication to my child, I must provide this completed and signed authorization form ***including both my initials next to applicable blanks above and signed below***. I understand that the prescription medication will be dispensed to the student by staff or chaperones I understand that the medicine must be brought to the school with complete instructions and in the **original** container with the Physician's order **or** pharmacy label firmly attached to the medication. I further understand that medication to be administered during the school day, at rehearsals, or on band trips must be brought to school by the Parent/Guardian and that ***all medications and paperwork for overnight trips must be turned in at least one week prior to the trip.***

I, the undersigned Parent/Guardian, request that an authorized staff member or chaperone administer the medication authorized by me on page one of this form to my child. For prescription medications, I agree to furnish the necessary prescribed medication and agree to notify LBA Medical Team Leader immediately of any changes. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of marching season, or the medication will be destroyed.

_____ _____
Parent/Guardian Signature Date

_____
Print Student Last Name/First Name

_____
Instrument

PHYSICIAN ORDER FOR MEDICATION FOR OVER THE COUNTER (OTC) MEDICATIONS MUST BE AUTHORIZED BY PARENT INITIALS BELOW

Physician Order Medication

Student's Name: _____ DOB: _____

Allergies: _____

School: _____ School Year: _____

See Medication List Below
Start Date: _____ Duration of Order: _____

Physician's Signature/Date _____

Telephone: _____ FAX: _____

Ibuprofen (Motrin, Advil) 200 mg - 1 to 2 tablets every 4 to 6 hours as needed for discomfort, no more than 6 tablets in 24 hours.

_____ Yes _____no

Acetaminophen (Tylenol Extra Strength) 500mg - 2 tablets every 6 hours as needed for discomfort, no more than 8 tablets in 24 hours.

_____ Yes _____no

Diphenhydramine (Benadryl) 25 mg - ½ to 1 tablet every 4 to 6 hours as needed for relief of allergy symptoms including itching, no more than 6 in 24 hours.

_____ Yes _____no

Antacid Calcium Rich (Tums, Rolaids) chew 2-4 tablets for symptoms, no more than 10 in 24 hours

_____ Yes _____no

Loperamide (Imodium) 2 mg chew 2 tablets after first loose stool then one after each subsequent stool not to exceed 4 tablets in 24 hours as needed for diarrhea.

_____ Yes _____no

Simethicone (Gas X) 125 mg chew 1 or 2 tablets after meals and at bedtime if needed for abdomen pain related to gas pain and pressure not to exceed 4 in 24 hours.

_____ Yes _____no

Meclizine Hydrochloride (Dramamine) 25 mg - 1 or 2 tablets as needed once a day one hour before activity that may lead to motion sickness, not to exceed 2 tablets in 24 hours.

I understand that someone in authority will make every attempt to contact me in the event my child requires medical attention.

_____ _____
Parent/Guardian Signature Date

Completed form must be turned in to the Chaperone on Duty by May 9, 2015 (Mini-Camp Saturday)
Mail option: LBA c/o Mike Booth * 1105 Foley's Retreat * Lexington, KY 40514