

**STUDENT HEALTH & INSURANCE FORM
PARENTAL CONSENT for MEDICAL TREATMENT**

Effingham County High School Bands
1589 Highway 119 South, Springfield, GA 31329
Phone: (912) 754-6404 ● Fax: (912) 754-6893
This form is valid for the 2017-2018 School Year.

-- THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC--

(Please submit unsigned if you don't have access to a notary. We will have a notary available at the new parent meetings on April 25 and 26, 2017.)

Student's Name _____	_____ Male	_____ Female	
Last	First	Middle	
Birth Date ____/____/____	Age _____	Grade at ECHS _____	
Address _____	_____	_____	
Street or PO Box	City	State	ZIP

I am the parent or legal guardian of _____. By signing this statement I give permission for my child to travel with the Effingham County High School Band program. I understand that my child needs to be on time to catch the bus, and that I need to be waiting to pick him/her up when the bus returns to the school (unless he/she is driving). I understand that if I am more than 30 minutes late, my child may be left with the Effingham County Sheriff's office on Highway 21 bypass.

By signing this consent form, I understand that during the trip my child will be subject to the policies, rules and regulations of the ECHS Bands (as outlined in the band handbook) and of the Effingham County Schools Code of Conduct. Proper attire must be worn at all times as outlined by the Effingham County Schools dress code. I understand that if my child violates these rules, he or she may be sent home early at my expense.

I understand that the medical information provided here is private. The ECHS Bands and Effingham County High School will not share this information with anyone except proper medical personnel in the event of an emergency.

Signature of Parent or Legal Guardian

Date

INSURANCE INFORMATION

Physician's Name _____ Telephone (_____) _____ - _____

Insurance Company _____

Policy Number _____ Insurance Company Telephone (_____) _____ - _____

Please INITIAL one of the following statements regarding insurance coverage for your child for the 2017-2018 school year:
____ My child is adequately and currently covered by accident insurance that will cover injuries sustained while participating in any school-authorized activities with the ECHS Bands.
____ I have purchased the Benefit Plan provided under the Effingham County School system. I understand this is a supplemental policy. My signed copy of the Benefit Plan is on file at the high school.

Signature of Parent of Legal Guardian

Date

MEDICAL HISTORY and MEDICINES

Please circle Yes or No for each of the following:

- Yes No 1) Has your child ever been hospitalized? If yes, name of hospital _____
- Yes No 2) Is your child taking any medication regularly? If yes, list medication and how often it is administered: _____

- Yes No 3) May your child be administered over-the-counter medicines if need be? If yes, list any over-the-counter medicines your child is allowed to take: _____

- Yes No 3) Does your child have any allergies (pollen, medicines, food, insect bites)? If yes, describe: _____

- Yes No 4) Does your child have any chronic or ongoing illness? If yes, list: _____
- Yes No 5) Has your child ever had surgery? If yes, describe: _____
- Yes No 6) Has your child received a tetanus immunization within the past 5 years? Date of immunization: _____

During any overnight or out-of-town trips, all medications must be given to the band directors or designated chaperone in their ORIGINAL containers. Please label the container with the child's name, and make sure the instructions are clear. This includes non-prescription medicines.

Mother/Legal Guardian	Father/Legal Guardian
Name _____	Name _____
Address _____	Address _____
Place of employment _____	Place of employment _____
Home Phone (_____) _____ - _____	Home Phone (_____) _____ - _____
Work Phone (_____) _____ - _____	Work Phone (_____) _____ - _____
Pager/Mobile (_____) _____ - _____	Pager/Mobile (_____) _____ - _____
Emergency contact person (in case the parent is unavailable): _____	
Relationship to student: _____ Phone (_____) _____ - _____	

AUTHORIZATION

I certify that the medical history provided on this form is complete and accurate. In case of an emergency or accident on school grounds or during any ECHS Band activity involving my child, I hereby grant permission to school authorities and/or designated chaperones to obtain the services of a physician or to transport my child to the hospital when such action is deemed necessary by said school authorities. I hereby grant permission for my child to be treated by a physician and/or emergency paramedic for emergency conditions until I can be contacted. I understand that every effort will be made to contact me in the event of an emergency. This acknowledgment of authorization shall remain in effect until revoked in writing.

I have carefully read, fully completed, and fully understand the contents of this document. I verify that this document has been completed fully and truthfully to the best of my knowledge.
(We will provide notary service at registration night and new parent meetings free of charge, please do not sign unless before a notary)

Signature of Parent or Legal Guardian Date

Sworn to me and subscribed before me this _____ day of _____, _____.

My commission expires _____.

Signature of Notary Public

NOTARY
PUBLIC
SEAL