

**BROOKFIELD H.S. BAND & GUARD**

**BROOKFIELD PUBLIC SCHOOLS  
PARENT/GUARDIAN PERMISSION AND MEDICAL FORM**

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_

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

Parent Contact: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Destination: \_\_\_\_\_

Purpose: \_\_\_\_\_

Date: \_\_\_\_\_ Leave: \_\_\_\_\_ Return: \_\_\_\_\_

Supervision: \_\_\_\_\_ Transportation: \_\_\_\_\_

Cost: \_\_\_\_\_ Dress: \_\_\_\_\_ Lunch: \_\_\_\_\_

I given permission for my child to attend these performances

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

\_\_\_\_\_  
Date

**MEDICAL HISTORY**

Date of Last Tetanus Booster: \_\_\_\_\_

Allergies: Insect Stings: \_\_\_\_\_

Food (List): \_\_\_\_\_

Drug (List): \_\_\_\_\_

Is your child under the care of a physician for a medical problem? Yes \_\_\_\_ No \_\_\_\_

If yes, please explain: \_\_\_\_\_

Is your child taking medication prescribed by a physician? Yes \_\_\_\_ No \_\_\_\_

If yes, please list all medications, dosage, time of administration, condition for which medication is being given and relevant side effects: \_\_\_\_\_

Other relevant information: \_\_\_\_\_

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**CONSENT**

To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) the administration of any treatment deemed necessary by a licensed physician or dentist and 2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of surgery.

Facts concerning the child’s medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted: \_\_\_\_\_

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

Additional medical history may be obtained from:

Doctor: \_\_\_\_\_

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

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

**REFUSAL TO CONSENT**

I do not give me consent for the emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take no action or to: \_\_\_\_\_

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

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

In the case of an emergency or an unanticipated danger, a planned trip may be cancelled at the discretion of the school principal or designee. In the event of this cause for cancellation, the district is not responsible for the loss of fees or payments incurred by families if expended monies cannot be returned.