

**Leander ISD Medication Consent
(2017-2018 / Leander High School Band)**

Participation in this program requires frequent travel for school events during the school year. Please provide the following information to be kept on file and keep the information up-to-date as needed.

Student Name: _____

I hereby give permission for my son/daughter to travel on transportation provided by Leander ISD to _____ **Band** functions during the **2017-2018** school year.

List any known drug/food allergies: _____

List medical conditions (asthma, contacts, etc.): _____

Non-Prescription / Over-the-Counter (OTC) Medication Authorization

If available, a First Aid kit, with approved OTC items, may be provided for minor ailments.

____ (initial) I **do not** give consent to staff to administer any non-prescription medication to my student.

____ (initial) I give consent to staff to administer non-prescription medications to my student as initialed below:

Please initial each medication that can be administered:

_____ Acetaminophen _____ Ibuprofen _____ Antihistamine/Decongestant _____ Sore Throat Lozenges

_____ Antacids _____ Anti-Diarrheal _____ Electrolyte _____ Menstrual Pain Reliever

I hereby certify that my student has no known drug allergies _____ (initial).

Prescription Authorization

I request that LISD staff administer medication/s listed below to my student according to the physician's instructions. I agree to furnish an adequate amount of medication in the original container at the time of travel.

Medication/s: _____

Note: Medications may be updated/added at the time of travel and additional forms may be attached as needed. Medications will be administered according to the physician's instruction on original container.

Parent/Guardian Signature _____

Phone (W) _____ **(C)** _____

2nd Emergency Contact Name _____

Phone (W) _____ **(C)** _____