

CLIFTON HIGH SCHOOL MUSTANG MARCHING BAND

Clifton High School Mustang Band Parents Association, Inc

P.O. Box 643

Clifton, New Jersey 07012

Trip to Washington, D.C. ~ April 12 - 15, 2012

STUDENT INFORMATION

Student and parent/guardian information provided in this document is confidential and will be accessed by the Trip Committee, Band Staff, and chaperones as required for the safety and well being of students participating in the trip.



Please print all responses.

Student _____ Male ____ Female ____
First name Last Name

Home address _____

Home telephone number _____ Date of birth _____

Mother / Legal Guardian _____
(circle one above) Full name

Mobile telephone _____ Work telephone _____

Father / Legal Guardian _____
(circle one above) Full name

Mobile telephone _____ Work telephone _____

Other address

If either parent or guardian will be at a different address other than the home address listed above for any day(s) of the trip, indicate that address and the appropriate dates here.

Other address _____ Telephone _____

Applicable dates _____

Emergency contacts (other than parent or guardian)

Name	Relationship to student	City and state	Telephone

This entire packet (5 pages) must be returned to Michael Molner, Trip Committee Chair, on or before the February 2012 Band Parent meeting. A Notary Public will be available at the February meeting.

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MEDICAL HEALTH STATEMENT

Student

_____ *First name*

_____ *Last Name*

1. Date of last Tetanus booster _____

2. Does your child suffer from any chronic illness? **No** ____ **Yes** ____

(e.g., asthma, diabetes, seizure disorder, etc.)

If YES, please be specific.

3. Does your child have any allergies or exhibit allergic reactions to any food, medicine or other substances and/or conditions? **No** ____ **Yes** ____

If YES, please list what your child is allergic to and describe the reaction that your child has upon exposure to that substance or condition.

4. Will your child need to take any prescription or non-prescription medication during the trip? **No** ____ **Yes** ____ **If YES**, please complete the chart below. Use a separate page if necessary.

Medicine	Dose	Times normally taken	Reason for medicine

Parents are reminded that ALL medications must be listed on this form. ONLY those medications listed above will be administered to your child. Any over-the-counter medications such as motion sickness remedies, antacids, cough syrup, allergy relief, Tylenol or Advil, homeopathic remedies, etc. must also be listed on this form. Medications of any kind that are not listed above will be confiscated.

A physician's signature is required to allow the accompanying trip nurse to administer medication, including over the counter medications.

Print physician name _____ **Telephone** _____

Physician signature _____ **Date** _____

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ADMINISTRATION OF MEDICATION

To ensure proper administration of all medicines for the duration of the trip, the following procedures must be followed.

1. All medications must be sent with the student on the day of departure. Do not pack in the suitcase.
2. All medications must be properly labeled in their **original** containers and placed in a labeled zip-lock bag.
3. All medications must be surrendered to the nurse or chaperone in charge on departure to Québec for proper storage and safekeeping. Medications will be dispensed as needed, with any unused medication returned at the conclusion of the trip.
4. If there are any last minute changes in your child's medication and/or health condition, please inform the trip nurse on the morning of the trip.

OTHER HEALTH CONCERNS

Wears eyeglasses **No** ___ **Yes** ___ Prescription OD (*right eye*) ___ OS (*left eye*) ___

Contact lenses **No** ___ **Yes** ___ Prescription OD (*right eye*) ___ OS (*left eye*) ___

Advice: If contacts are worn, a spare pair of glasses should be brought on the trip. Also, if an eye infection is likely to occur from contacts, medication should be obtained for the student prior to the trip.

Describe any personal difficulties likely to be experienced during the trip.

Include any additional information that would be important for the Band Director and Trip Committee.

HEALTH INSURANCE

Health insurance provider _____ Policy # _____



A photocopy (front and back) of the medical insurance card must accompany this information packet.

PERMISSION AND WAIVER

I hereby give permission for _____ to receive medical treatment by a
(*student name*)
qualified physician in his office or in a hospital emergency room in the event of accident or serious illness.

Signature **PARENT / LEGAL GUARDIAN**

Printed name **PARENT / LEGAL GUARDIAN**

Date

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TRIP PERMISSION SLIP

I/we hereby give permission for _____ to participate in the
CHS Mustang Band trip to Washington, D.C., from April 12 - 15, 2012.

Signature **MOTHER / LEGAL GUARDIAN**

Printed name **MOTHER / LEGAL GUARDIAN**

Date

Signature **FATHER / LEGAL GUARDIAN**

Printed name **FATHER / LEGAL GUARDIAN**

Date

I hereby certify that, on _____,
date

_____ and _____
Parent / Legal Guardian *Parent / Legal Guardian*

personally appeared before me and acknowledged under oath to my satisfaction that they are the
persons who personally executed the above instrument and signed, sealed, and delivered this
instrument as their voluntary act and deed.

NOTARY PUBLIC
My commission expires:

Date

(Seal)