

Burges High School Band
Medication & Permission for Emergency Medical Treatment
2018/19 School Year
PLEASE COMPLETE BOTH SECTIONS OF THIS FORM AND
SIGN AT THE BOTTOM

Section I

Full name of student: Last: First: _____

Student's date of birth: _____ Student's Cell: _____

Section II

My child is ALLERGIC to the following foods or medications. If none, please write NONE.

My child takes the following prescriptions/medications regularly:

Other special conditions:

I understand and acknowledge that the Chaperones, Band Boosters, Burges High School, any faculty, staff, administrative personnel or representatives of the El Paso Independent School District, and the El Paso Independent School District are not liable for any complications which might occur as the result of the administration of such first aid measures I give permission for my child to receive.

Signature of Parent/Guardian Date