I hereby give permission for the CFHS Band Staff and/or Parent Chaperone(s) to contact my student directly by phone/text with any information or instructions with regard to the medication(s) that my student needs to take during the dates described below.

Student's Name: _____

Student's Section: _____

Student's Phone number: (____) _____

Date(s) of Event: _____

Parent/Guardian Name:_____

Parent/Guardian Signature: _____

Parent/Guardian Phone Number: _____

Catalina Foothills School District
Medical Consent and Record Form

All medications must be given to the teacher/sponsor in the original prescription or over-the-counter (OTC) container labeled with the student's name, with only the amount needed for the duration of the trip. Medications and consent form are to be given to teacher/sponsor 1 week prior to the trip. An updated form must be completed per trip, as medications, dosages and contact information may change. **If OTC dose is greater than recommended on bottle, a physician's prescription is required.**

Student Name_____ **DOB:**_____ **Grade:**_____

1st Medication_____ Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

2nd Medication_____ Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

3rd Medication_____ Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

4th Medication_____Amt. Received: _____ Amt. Returned _____ Parent Initial _____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

5th Medication_____Amt. Received: _____ Amt. Returned _____ Parent Initial _____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

I understand that all prescription and OTC medication is to be furnished by me in the **original container with the original label.**

Parent/Guardian Signature: _____

Health offices will provide needed student medication from the health office supplies for day field trips.

Parents will provide needed student mediation (including OTC) from home for overnight trips.

NOTARIZATION REQUIRED FOR OUT OF STATE AND INTERNATIONAL TRIPS.

Sworn and subscribed to before me _____of the County of _____

State of Arizona, this _____day of _____, 20____.

_____
Signature of Notary

My commission expires: _____