**Sherando High School Band Medical Permission Form**
**INDOOR PERCUSSION/WINTER GUARD - 2026-2027 School Year**

Student Name: _____

If considered necessary by the directors or chaperones during band trips, my child may be given appropriate over-the-counter medications such as pain relievers, antihistamines, decongestants, upset stomach relief, insect bite/sting relief, etc. (Please initial.)

_____ YES _____ NO

If yes, my child should NOT be given the following OTC medications:

_____

In the rare event of an emergency or concern, it may be necessary to seek emergency medical treatment for your student. By signing below, you give the directors, staff, and adult chaperones authority to obtain any medical services deemed immediately necessary by attending physicians and agree to be financially responsible for any expenses incurred. The directors, staff, and chaperones will use their best judgment and will act in the best interest of the good health of the student and the group.

Parent Name: _____

Parent Signature: _____

Parent Phone Number: _____

Date: _____