Huntington Blue Devil Marching Band
2021 Member Packet

Congratulations! You are a member of the Huntington Blue Devil Marching Band. We are excited to begin the 2021-22 season. Please read through the instructions below and the packet thoroughly.

- **Each member and parent/guardian must complete and sign ALL forms in this packet.**
- This packet is **DUE AUGUST 16, 2021.** (1st day of training camp)
- **Do not separate this packet.**
- **Please print neatly.**

In efforts to save paper, a hardcopy of this handbook will be distributed via request only for members who do not have access to the internet.

- **Please read everything before signing.**
  If you have any questions, please contact:
  Mr. Stellato at bstellato@hufsd.edu or
  Ms. Martilla at hbdmb.asst.dir@gmail.com or
  Mr. Neary at hbdmb.co.direct@gmail.com

CONTENTS: Please make sure all parts are signed and dated:

Huntington Blue Devil Marching Band
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Health Screening and Emergency Contact Form

Student Information

Student Name: _____ Date of Birth: _____/_____/_____

Sex: (circle one) Male / Female

Student address:_____

_____, NY, _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Grade 2021/22 - school year: (circle one) 7 8 9 10 11 12

Parent Information

Parent Name:_____ Cell Phone (_____) _____-_____

Parent Name:_____ Cell Phone (_____)_____-_____

Authorized Alternate Emergency Contact:

Name: _____ Relationship: _____

Phone: (_____) _____-_____

Name: _____ Relationship: _____

Phone: (_____) _____-_____

Family Doctor & Insurance Information:

Family Doctor: _____ Phone: (_____) _____-_____

Insurance Company: _____ Policy Number: _____

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STUDENT MEDICAL HISTORY: Date of Last Tetanus Shot: _____/_____/_____

CARDIOVASCULAR/RESPIRATORY

Please check if your child has a history of:

_____Heart or Lung Trouble
_____Chronic Tiredness
_____High Blood Pressure
_____Chest Pains with Exercise
_____Dizziness or Faintness with Exercise
_____Palpitations
_____Rapid or Irregular Heartbeats
_____Rheumatic Fever
_____Other_____

BLOOD

Please check if your child has a history of:

_____Tendency to Bleed/Bruise Easily
_____Anemia
_____Hepatitis
_____Mononucleosis
_____Other_____

DIGESTIVE

Please check if your child has a history of:

_____Frequent Pain in Abdomen
_____Ulcers
_____Other_____

NEUROLOGICAL

Please check if your child has a history of:

_____Brain Concussion (Head Injury)
_____Fainting Spells
_____Skull Fractures
_____Recurring/Severe Headaches
_____Convulsions/Epilepsy
_____Other_____

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EYES/EARS/NOSE/THROAT

Please check if your child has a history of:

_____Hearing Loss

_____Frequent Nose Bleeds

_____Other_____

_____Sinus Infection

_____Deviated Septum

ORTHOPEDIC

Please check if your child has a history of:

_____Bone Fracture

_____Foot Problems

_____Neck Injury

_____Knee Injury/Recurring Pain

_____Other_____

_____Joint Dislocation

_____Spine/Limb Deformity

_____Back Injury/Frequent Backaches

_____Ankle Injury/Recurring Pain

ALLERGY

Please check if your child has a history of:

_____Hay Fever

_____Frequent Hives or Rashes

_____Asthma

_____Reaction to Medication: (List Below)

_____

_____

_____

_____Other_____

_____Reaction to Insect Stings: (List Below)

_____

_____

_____

_____Other_____

MEDICATION

Does your child take any medications regularly? (circle one) Yes No

If YES, list any and all medications:

_____

_____

Does your child take any medications for emergency use? (circle one) Yes No

If YES, list any and all medications:

_____

_____

If you checked any of the above conditions, please explain in the space below:

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AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I, _____, am the parent/legal guardian
First Name/Last Name

of _____, a minor child who was born
First Name/Last Name

on _____, and whose age is _____, and who resides at:

_____NY, _____
Street Town Zip Telephone

In the County of Suffolk, State of New York.

I give permission for an adult chaperone provided for this trip by the Huntington Union Free School District, in the County of Suffolk, State of New York, to authorize emergency treatment which may be necessary for my minor child named above, while participating in this trip, when efforts to contact me are unsuccessful or not possible. Such treatment to include, but not be limited to: examinations, x-rays, laboratory tests, medical and surgical treatment, use of medication, anesthetics, sutures and admission for hospital care as may be required.

It is understood that such care will be upon the advice of a duly licensed physician or surgeon.

_____

Parent/Guardian Signature (person responsible for payment of emergency care or treatment) Date: _____

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Medication Form

Standard Over the Counter Medications

The following medications are available in the Health Center with parent/guardian AND physicians approval. Please select which medication below can be administered or taken self-directed.

☐ **Check here to decline over the counter Medications**

Parent Signature_____

Key: PRN (if needed) PO (taken by mouth) Topical (applied to skin) Q (every)

Drug Name	Route	Dosage	Schedule and Indications	Health Care Provider Order	Comments
Motrin/Ibuprofen	PO (chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Tylenol/Acetaminophen	PO (chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Robitusin/Robitusin DM	PO (liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Coughs	YES NO	
Benadryl/Diphenhydramine	PO/Topical (pills, liquid or spray)	Per label instruction by age/weight	PRN - Insect bites, allergies, respiratory allergies	YES NO	
Caladryl, Calagel & Hydrocortisone	Topical (cream)	Per label instruction	Q 6-8 hrs PRN Rash, skin irritation	YES NO	
Calamine	Topical (cream or gel)	Per label instruction	PRN - Insect bites, skin irritation, rash	YES NO	
Bacitracin	Topical (cream or liquid)	Per label instruction	PRN - Stings/bites, cuts, scrapes, splinters, blisters	YES NO	
Dimetapp	PO (elixer of tabs)	Per label instruction by age/weight	Q 6-8 hrs Nasal congestion/drainage	YES NO	

Dramamine	PO (chewable tabs)	Per label instruction by age/weight	Q 6-8 hrs Motion Sickness	YES NO	
Loperamide HCL	PO (tabs of liquid)	Per label instruction by age/weight	Two tabs after first loose stool, followed by one tab after each additional stool. No more than 4 tabs in 24 hours	YES NO	
Mylanta	PO (chewable tabs, elixir, or tabs)	Per label instruction by age/weight	BID-TID PRN Upset stomach	YES NO	

Licensed Physician's Signature _____License #_____

Address _____Phone (_____) _____-_____
Date of Form Completion_____/_____/_____By_____
Initial if completed by nurse or physician's assistant

Parent/Guardian Signature _____ Date _____/_____/_____

Prescription Medications

I request that my patient as listed below, receive the following prescription medication(s) including PRNs:

Name of Student: _____Date of Birth: _____/_____/_____
Diagnosis: _____or circle N/A

Name of Medication(s):_____or circle N/A

Prescribed Dosage, Frequency and Route of Administration: _____or circle N/A

_____

Time to be taken daily during school trip(s):_____or circle N/A

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Local Competition Permission Slip

FIELD TRIP PARENTAL CONSENT

I hereby give permission for my child, _____ to participate in school sponsored Education field trips to local HBDMB competitions. I understand that my child will travel to the following locations on the attached dates:

DATE:	LOCATION:	TRANSPORTATION:
Sunday, September 19	Brentwood High School	District approved school bus
Sunday, September 26	Copiague High School	District approved school bus
Saturday, October 2	Malverne High School	District approved school bus
Sunday, October 10	Arlington High School	District approved school bus
Saturday, October 16	Sachem High School	District approved coach bus
Saturday, October 23	Mineola High School	District approved school bus

*MEDICAL INFORMATION

**All pertinent medical information has* been included in the HBDMB Medical Form

STUDENT'S RESPONSIBILITY

I agree to behave in an appropriate manner on this field trip and cooperate with the teacher and/or chaperone at all time. I also agree to abide by any rules set by the teacher in charge and agree to follow the District Code of Conduct. I realize that failure to act in an appropriate manner or to abide by school district policies, or special teacher rules, will result in a suspension from school and suspension from field trips for the remainder of the school year and possibly a more extended period of time, depending on the date of the field trip.

_____ _____ _____

Student Signature *Student Name (Print)* *Date*

_____ _____

Parent/Guardian Signature *Date*

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Overnight Field Trip Permission Slip

Student's Name: _____

Trip Date(s): October 30, 2021- November 1, 2021

Group: Huntington Blue Devil Marching Band

Destination: Syracuse, NY Mode of Transportation: Coach Bus

I hereby give permission for my child to participate in this Huntington Schools Overnight Field Trip.

In the event of a medical emergency, the procedure on this trip will be to call the parent or guardian, time permitting, before taking a student to a medical facility. However, when neither one can be reached, the following permission will allow prompt attention.

We/I hereby give permission for the School District's trip leader(s) or designee(s) to transport our/my child to or from a hospital for emergency treatment.

We/I hereby give permission for the School District's trip leader(s) or designee(s) to sign any consent forms which may be necessary to allow hospital personnel and/or licensed physician to examine our/my child and perform any emergency procedures or surgery, or render any emergency treatment which may be necessary, and to consent to the administration of any drugs or medication necessary to render such emergency care.

We/I hereby do release the Huntington Union Free School District, members of its Board of Education, employees, agents, volunteers, and trip chaperones, and to hold them harmless and indemnify them from demands, liabilities, and causes of action arising out of, or connected to personal injury, illness, death, or property damage resulting from any cause whatsoever other than their own negligence, and for any expenses incurred in the rendering of or arising out of any care and treatment so provided.

We/I understand that in the event of an illness when in the judgment of the principle trip leader(s), nurse, or doctor, it is in the best interest of the child for him/her to be taken or sent home, that the parent or guardian will assume the responsibility for providing said transportation home.

_____ _____

Parent/Guardian signature Date

_____ _____

*Parent/Guardian signature Date

*Form is to be signed by both parents/guardians unless legal custody is by one parent only.