



Huntington Blue Devil Marching Band

2024 Member Packet

Congratulations! You are a member of the Huntington Blue Devil Marching Band. We are excited to begin the 2024-2025 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 12th, 2024.** (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. Rizzuto at arizzuto@hufsd.edu or
Ms. Martilla at martillam1025@gmail.com or
Mr. Neary at hbdmb.co.direct@gmail.com

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

- Pages 2-7: Health Screening and Emergency Contact Form (Filled out by **Parent** and **Physician**)
- Pages 6-7: Trip Medication Form (**Physician Signature Required**)
- Page 8: Local Competition Permission Slip
- Page 9: Overnight Field Trip Permission Slip

Health Screening and Emergency Contact Form

Student Information

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

Sex: (circle one) Male / Female

Student address: _____



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_____, NY, _____

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

Grade 2023/24 - 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: _____ Date of Last Tetanus Shot: _____

Policy Number: _____

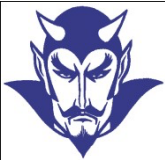
STUDENT MEDICAL HISTORY: _____ / _____ / _____

CARDIOVASCULAR/RESPIRATORY

Please check if your child has a history of:

_____ Heart or Lung Trouble

_____ Chronic Tiredness



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- | | |
|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pains with Exercise |
| <input type="checkbox"/> Dizziness or Faintness with Exercise | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Rapid or Irregular Heartbeats | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Other _____ | |

BLOOD

Please check if your child has a history of:

- | | |
|--|--|
| <input type="checkbox"/> Tendency to Bleed/Bruise Easily | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Other _____ | |

DIGESTIVE

Please check if your child has a history of:

- | | |
|---|---------------------------------|
| <input type="checkbox"/> Frequent Pain in Abdomen | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Other _____ | |

NEUROLOGICAL

Please check if your child has a history of:

- | | |
|---|---|
| <input type="checkbox"/> Brain Concussion (Head Injury) | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Skull Fractures | <input type="checkbox"/> Recurring/Severe Headaches |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Other _____ |

EYES/EARS/NOSE/THROAT

Please check if your child has a history of:

- | | |
|---|--|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Frequent Nose Bleeds | <input type="checkbox"/> Deviated Septum |
| <input type="checkbox"/> Other _____ | |

ORTHOPEDIC

Please check if your child has a history of:

- | | |
|--|---|
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Joint Dislocation |
| <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Spine/Limb Deformity |



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____ Neck Injury

____ Back Injury/Frequent Backaches

____ Knee Injury/Recurring Pain

____ Ankle Injury/Recurring Pain

____ Other _____

ALLERGY

Please check if your child has a history of:

____ Hay Fever

____ Asthma

____ Frequent Hives or Rashes

____ Reaction to Medication: (List Below)

____ Reaction to Insect Stings: (List Below)

____ Other _____

____ Other _____

MEDICATION

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

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

If YES, list any and all medications:

If YES, list any and all medications:

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

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:

Street Town NY, _____
Zip Telephone



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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: _____

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 (if declining medications) _____

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



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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	
Robitussin/Robitussin 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 (elixir 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	



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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:

Education field trips to local HBDMB competitions. I understand that my child will travel to the following locations on the attached dates:

<u>DATE:</u>	<u>LOCATION:</u>	<u>TRANSPORTATION:</u>
Sunday, September 15 th	Brentwood High School	District approved school bus
Sunday, September 22 nd	Copiague High School	District approved school bus
Saturday, September 28 th	Malverne High School	District approved school bus
Sunday, September 29 th	Roslyn High School	District approved school bus
Sunday, October 6 th	Sachem High School	District approved school bus
Sunday, October 13 th	Arlington high School	District approved coach bus
Saturday, October 19 th	Hampton St. Stadium	District approved school bus
Saturday, October 20 th	Huntington High School	
Sunday, October 27 th	Championships, JMA Arena, Syracuse, NY	District approved 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 times. 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

Parent Name (Print)

Date



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Overnight Field Trip Permission Slip

Student's Name: _____

Trip Date(s): October 26th-28th, 2024

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.