Marathon Dance 2024
Permission Sheet & Medical Information

Student's Name _____ Grade _____

By signing below I hereby give *(dancer's name)* _____ permission to participate in the 28 hour South High Marathon Dance, which is a South Glens Falls Central School District event. I understand that at some point during the 28 hour Marathon Dance I may need to be contacted. In case of an emergency, I can be reached at:

Cell Phone: _____ Home Phone: _____ Other: _____

I also give permission for the South High Marathon Dance to record, take statements, transcribe and photograph the above named student which may be distributed, posted, or broadcast through media, internet, and other means in conjunction with any Marathon Dance – related project. By signing this release, I acknowledge that South High shall own the copyright in the photographs, statements, transcriptions and recordings they make of the Dancer. Since the Marathon Dance is a community event, I also give unrestricted permission for my child's image/statements to be used by the media covering this event without further notification.

Parent or Legal Guardian's Name: _____

Street Address _____

City _____ Zip Code _____

Does the student have any medical problems that we should be aware of? (Explain) _____

_____

List **ALL** medications the student will need/have during the dance (OTC and Prescribed). **ONLY** complete the medication administration form on the back of this sheet for controlled substances or medication the nurse will be administering.

_____

_____

Please remember to turn in all CONTROLLED medications during registration to the medical staff. Any OTC or regularly prescribed medications must be kept secured with the dancer's belongings. SHMD will not be responsible for any medications that are lost/stolen.* <u>Any controlled medication found without the accompanying Doctors order on the back of this permission sheet cannot be administered and will therefore be collected and disposed of properly.*</u>

By signing, I give permission to the medical staff at South High Marathon Dance to treat the above mentioned dancer as needed for any illness/injury (including transporting via ambulance for further care)

Parent or Guardian's Signature _____ Date _____

Parent and Prescriber's Authorization for Medication at the **South High Marathon Dance**

To be completed by the licensed health care prescriber:

I have prescribed the following medication for: GRADE: _____

Name of student: _____ Date of Birth_____

Diagnosis: _____

Name of Medication: _____

Prescribed dosage, frequency and route of administration: _____

_____

Time to be taken **during dance hours**: _____

Duration of treatment: _____

Possible side effects and adverse reactions (if any): _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____

Address: _____

Phone: _____ Date: _____

Provider must **initial** appropriate box below

☐ **Administration of Medication by Health Care Provider during SHMD**

I request that my child _____ receive medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled container from the pharmacy **WITH ONLY THE QUANTITY NECESSARY**. I understand that the school nurse or other assigned person will administer the medication.

☐ **Self -Administration of Medication during SHMD**

(By checking the box you are authorizing this student to carry and use the above medication(s) by him/herself)

I request that my child _____ be permitted to carry the above medication(s) in the properly labeled container **WITH ONLY THE QUANTITY NECESSARY** on his/her person or to keep the above prescribed medication in his/her locker, as I consider him/her responsible. The student has been instructed in and understands the purpose, appropriate method, frequency and use of this medication. The student understands that he/she is responsible and accountable for carrying and using this medication. It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.

Signature (Parent or Guardian): _____

Address: _____

Telephone (Home): _____