

# PENDLETON HEIGHTS HIGH SCHOOL BAND MEDICAL FORM 2011-2012



PLEASE SUBMIT A PHOTO COPY OF YOUR HEALTH INSURANCE CARD(S)  
ALONG WITH THIS FORM

## **Student Information**

Student Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

## **Parent Information**

Father's Name \_\_\_\_\_ Home No. \_\_\_\_\_ Work \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home No. \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Co. and Policy Number \_\_\_\_\_

\_\_\_\_\_ Policy Holder's date of birth \_\_\_\_\_

SS # of Policy Holder \_\_\_\_\_ Student SS # \_\_\_\_\_

## **Emergency Contact Person** (Other than parent)

Name \_\_\_\_\_ Home No. \_\_\_\_\_ Work No. \_\_\_\_\_

### **MEDICAL RELEASE STATEMENT**

**I understand that, in the event that medical treatment is required, every effort will be made to contact me. If I can not be reached, I give my permission to the Pendleton Heights High School Band staff to secure the services of a licensed physician to provide the care necessary for my student's well-being. I understand that this may be in a physician's office or in an emergency facility. I also understand that I or my insurance company will be responsible for the medical costs incurred.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**-OVER-**

# Student Medical History

Allergic to any medications: \_\_\_\_\_

\_\_\_\_\_

If so, what type of reaction: \_\_\_\_\_

Any other allergies? \_\_\_\_\_

If allergic to bee stings, what type of reaction and how do you treat it? \_\_\_\_\_

\_\_\_\_\_

Year of last tetanus shot: \_\_\_\_\_

Does student wear glasses? \_\_\_\_\_ Contact lenses? \_\_\_\_\_

List any medical conditions that might be necessary to know in case of an emergency

\_\_\_\_\_

\_\_\_\_\_

Asthma? \_\_\_\_\_ If your child has asthma or uses inhalers, nebulizers, or any breathing aids, list here and be sure to send them with your student \_\_\_\_\_

\_\_\_\_\_

Please list any medications that your student might need or will be taking while traveling with the band/guard. **Medications will become the responsibility of the student to administer to themselves** unless the parent so notes the preference for a chaperone to administer the medication (s). Medications should be in a bottle with the original label.

\_\_\_\_\_

\_\_\_\_\_

In the event of your child asking a chaperone for any "over the counter" medication, is there anything he/she should not have? \_\_\_\_\_

\_\_\_\_\_

List any additional information that might be helpful to us concerning the care of your child

\_\_\_\_\_

\_\_\_\_\_

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