

UNIVERSITY HIGH SCHOOL BAND STUDENT HEALTH FORM

___ Health Problems
___ Allergies

1. Student's Name: _____
(LAST) (FIRST) (MIDDLE)

2. Date of Birth: ____/____/____ 3. Home Phone Number: _____

4. Address: _____

(STREET)

(CITY)

(STATE)

(ZIP)

5. Parent/Guardian Name: _____

6. Parent/Guardian E-mail: _____

7. Parent/Guardian Employer: _____

8. Parent/Guardian Work Phone: _____

9. Emergency contact if a parent/guardian cannot be reached: _____

(NAME)

(PHONE NUMBER)

10. Does student have insurance through parent employer? _____ Yes _____ No

11. If yes, name of insurance company: _____

12. Policy number: _____

13. Student's physician: _____ 14. Physician's phone number: _____

15. Health History: (check all that apply)

16. Allergies: (check all that apply)

___ Diabetes

___ Aspirin

___ Orthopedic Problems

___ Penicillin

___ Asthma

___ Sulfa

___ Epilepsy

___ Insect Stings/Bites

___ Cardiac Problems

___ Tetracycline

___ Other (Specify) _____

___ Other (Specify) _____

17. Any condition now requiring regular medication? _____ Yes _____ No

18. Name of medication: _____ 19. Who administers? _____

20. Has student had a tetanus shot current within six years? _____ Yes _____ No

21. Do we have permission to administer to your child? (check all that apply)

___ Pepto-Bismol ___ Tylenol ___ Advil ___ Dramamine

22. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? _____ Yes _____ No

If yes, please explain: _____

I give permission to the physician or hospital to secure proper treatment for and to order medications, injections, anesthesia or surgery for my child as named above.

(PARENT/GUARDIAN SIGNATURE)

(DATE)