PENDLETON HEIGHTS HIGH SCHOOL BAND MEDICAL FORM 2010-2011

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-

<u>Student Medical History</u>

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 _______________________

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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.

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

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

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PLEASE ATTACH A PHOTO COPY OF YOUR INSURANCE CARD(S)