

HEALTH FORM

RETURN **ASAP** TO BHS MUSIC DEPARTMENT

Students will not be allowed to participate in marching band with an incomplete form!

Student Name: _____ **Date of Birth:** _____

Address: _____

Home Phone: _____

Cell Phone: _____

Pager: _____

Father's Name _____ **Work Number:** _____

Mother's Name _____ **Work Number:** _____

Emergency Contact Person

Name _____ **Relationship** _____

Phone Number: _____

Doctor _____ **Phone** _____

Insurance Company _____ **Policy #** _____

Name of Insured _____ **Group #** _____

Insurance Company Phone # _____

Does your child have any pre-existing conditions that could affect their ability to participate in marching band activities? Yes ___ No ___

If yes, please explain: _____

Does your child require any medical treatments, such as inhalers, nebulizers, glucose monitoring?

Yes ___ No ___ If yes, please list the treatment, frequency and times needed. _____

Does your child have any allergies to food, medication or other substances? Yes ___ No ___

If yes, please list the allergen and their specific reaction. _____

The above needs to be addressed with you and your doctor. It is the responsibility of the parent and child to be prepared during rehearsals and scheduled activities. (i.e. inhalers, etc. must be provided by and kept with the child). Any emergencies that may arise will be handled.

Does your child take any medication: Yes ___ No ___

This includes both prescription medications as well as over the counter medications (such as Tylenol, Advil, Benadryl, etc.)

If yes, please list the name of the medication, the dose, when taken and why they take it. _____

Date of last tetanus shot? _____

I give permission for immediate medical treatment as required in the judgement of the attending physician. Notify me as soon as possible.

Signed _____ Date _____

I DO NOT give permission for medical treatment until I have been contacted.

Signed _____ Date _____