HEALTH FORM 2017 - 2018
Plainfield High School Band

To be filed out by Parent or Guardian:

Student Name _____ Grade _____
Date of Birth_____ Height _____ Weight _____
Male/Female_____ Instrument/Guard_____
Student's cell _____ Student's email_____
Home Address_____
Street City Zip

Name of Parent 1/Guardian 1 _____
Telephone (h) _____ (w) _____ (c) _____
E-mail address_____
Home Address_____
Street City Zip

Name of Parent 2/Guardian 2 _____
Telephone (h) _____ (w) _____ (c) _____
E-mail address_____
Home Address_____
Street City Zip

<u>If Person Above is Not Available In Event of Emergency, Please Notify:</u>

Name_____ Phone _____
Relationship_____

Name of Personal Physician _____Phone _____
Personal Health/Accident Insurance Carrier_____
Policy Number_____If **no** health insurance, check here ☐

Medical Information PAST or PRESENT (please cheek):

Asthma	Y☐ N☐	Diabetes	Y☐ N☐
Allergies	Y☐ N☐	Leukemia	Y☐ N☐
Convulsions/Sei	Y☐ N☐	Cancer	Y☐ N☐
Heart Disease	Y☐ N☐	Hemophilia	Y☐ N☐

Please list any allergies the student has. _____
Explanations:_____

Any reasons to restrict full activity (physical or emotional) Y☐ N☐ If yes, give all information needed to provide as safe and full participation as possible._____
_____
_____

Is there any reason for medication to be taken? (see page 2) Y☐ N ☐

List any special equipment such as orthopedic or handicap devices, glasses, contacts or dentures.

_____

Please provide date of the last tetanus inoculation. (Note that boosters are updated around age 15 or 16. Check with your physician to see if a booster is needed.)

TETANUS TOXOID _____
BOOSTER_____

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL/TRIP

Name of Student: _____
School _____

Students with asthma are allowed and encouraged
to carry their inhaler at all times.

Please list any **prescription or OTC/non-prescription** medication, including asthma inhalers, the condition for which medication is being administered, and dosage information:

	Dosage and time to be given
_____	_____
_____	_____
_____	_____

Other than an asthma inhaler, will your student be taking any of the above listed medications while at any band activity? Y☐ N ☐

May your student be given any of the following over-the-counter medication when needed? Please indicate dosage.

Tylenol Y☐ N ☐ Dosage_____
Advil Y☐ N ☐ Dosage_____
Midol Y☐ N ☐ Dosage_____

FOR <u>OVER-THE-COUNTER NON-PRESCRIPTION</u> ITEMS, A PARENT SIGNATURE IS SUFFICIENT.

PARENTS SIGNATURE_____ DATE: _____

☐ ***By checking this box, I understand that I have signed this form electronically as my digital signature.***

FOR <u>PRESCRIPTION</u> DRUGS, THIS FORM MUST BE SIGNED BY BOTH PARENT AND PHYSICIAN.

PHYSICIAN SIGNATURE_____ DATE: _____

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, which may include hospitalization, anesthesia, surgery or injections of medicine.

Parent/Guardian Signature: _____ Date:_____

☐ ***By checking this box, I understand that I have signed this form electronically as my digital signature.***