HEALTH FORM 2023 - 2024

Plainfield High School Band

To be filled 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

If Person Above is Not Available In Event of Emergency, Please Notify:

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/Seizures	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 _____

Name of Student: ____ Grade _______

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

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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 ______________________________

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AUTHORIZATION TO GIVE MEDICATION AT SCHOOL/TRIP

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:

Medication Name	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.

PARENT'S 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: ____________________________

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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.***

☐ ***Check this box if you want to be notified if your student visits the first aid tent for a non-emergency.***

These forms go with your student wherever they go.
Please update the forms if there are changes throughout the year.