

DAVISS COUNTY

Band of Pride

HEALTH FORM

Student Name: _____ Age: _____

Date of birth: _____ Sex: _____

Mailing Address: _____

Home Phone: _____

Cell Phone - Mother: _____ Father: _____

Parents/Guardians _____

Place(s) of Employment _____

Work Phone(s) _____

IN AN EMERGENCY, IF UNABLE TO CONTACT PARENT/GUARDIAN, PLEASE NOTIFY:

Name: _____

Relationship to Child: _____

Home Phone: _____ Work Phone: _____

In the event of a medical emergency, I authorize Mr. Dale, Mr. Clark, or their designated chaperones to seek emergency medical care for my child.

Parent Signature

Date

HEALTH HISTORY (YES OR NO IN EACH SPACE AND EXPLANATION OF YES IN SPACE BELOW OR AND ATTACHMENT)

ASTHMA:____EPILEPSY:____ORTHOPEdic PROBLEMS:_____

DIABETES:____FAINTING:____ OTHER:_____

EXPLANATION:_____

ALLERGIES:_____ (Yes or No)

Specify type(s):

MEDICATIONS CURRENTLY TAKING/USING - All prescriptions and Non-Prescription ORAL medications and prescription EXTERNAL medication such as inhaler, anticonvulsive, antihistamine, antifungal, acne, insulin, ritalin, etc. Please give medication name(s):

RECENT SURGERY/PROCEDURES/ILLNESS(within 1 year)

IS YOUR CHILD UNDER ANY MEDICAL TREATMENT AT PRESENT (SPECIFY IF YES) OTHER THAN MEDICATIONS ALREADY LISTED?

IS THERE ANYTHING ELSE THAT SHOULD BE CALLED TO THE ATTENTION OF THE BAND DIRECTOR OR MEDICAL PERSONNEL?

PHYSICIAN'S NAME _____

PHONE # _____

FAMILY INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

GROUP NUMBER _____

I.D. NUMBER _____