

2018 - 2019 STUDENT HEALTH INFORMATION

Student Information

Student Name: _____ DOB: _____ Grade: _____

Parent/Guardian Information

Mother's Name: _____ Father's Name: _____

Mother's Cell: _____ Father's Cell: _____

Emergency Contact *(in addition to parents)*

Name: _____ Relationship: _____ Phone: _____

Medical Information

Primary Physician: _____ Phone: _____

Known Allergies: _____

Current Medications: _____

Insurance Information

Insurance Provider: _____ Policy #: _____

** place a checkmark beside any of the following that your child has had in the past two years **

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle/Joint Disorders |
| <input type="checkbox"/> Use Inhaler? <i>(circle) Yes / No</i> | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Physical Impairments |
| <input type="checkbox"/> Cancer/Tumor <i>(List type below)</i> | <input type="checkbox"/> Seizure/Epilepsy |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Colon Disorder <i>(Crohn's/Ulcerative Colitis/Irritable Bowel)</i> |
| <input type="checkbox"/> Heart Condition/Murmur | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Nose Bleed |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Frequent Urinary Tract Infection |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Other Significant Health Problems <i>(List below)</i> |
| <input type="checkbox"/> Eating Disorder/Special Diet | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stomach Ulcer/Reflux | |

Explain any conditions checked above:

** In the case of medical emergency, I hereby give permission to hospitalize, secure treatment for, and/or to order injection or surgery for my child. I understand that the undersigned will be responsible for any and all medical or hospital bills. I give my child permission to participate in all band trips and related activities**

Parent Signature: _____

Date: _____