

GLENELG HIGH SCHOOL MUSIC DEPARTMENT

2008-2009 MEDICAL FORM

Student Name: _____
 Cell Phone: _____
 Home Phone: _____
 Address: _____
 City/State/Zip: _____
 Student Email: _____

Unit: Band Drill Team Silks
Grade: 9 10 11 12
Social Security Number: _____
Insurance Company: _____
 Policy #: _____
 Address: _____
 City/State/Zip: _____

***A copy of the front and back of the insurance card must be attached to this form.**

Mother's Name: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Mom Email: _____

Doctor's Name: _____
 Phone: _____

Father's Name: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Dad Email: _____

Dentist's Name: _____
 Phone: _____

Orthopedist's Name: _____
 Phone: _____

HEALTH HISTORY

Date of student's most recent Tetanus Shot: _____

Please answer YES or NO to all questions.

Is student presently taking any medication? _____

Type and frequency: _____

Concerns: _____

Does student have permission to self-medicate? _____ (All meds will be kept in student's possession)

Is student authorized to administer:

Ibuprofen _____	Aspirin _____	Sudafed _____	Motion Sickness Medicines _____
Tylenol _____	Anacin _____	Benedryl _____	Non-medicated Cough Drops _____
Excedrin _____	Motrin _____	Laxative _____	Antacid Tablets _____
Bufferin _____	Midol _____	Eye Drops _____	Immodium _____
		Other _____	_____

Has student had, or does student have:

Diabetes _____	Low Blood Pressure _____	Orthopedic Problems _____
Asthma _____	Cardiac Problems _____	Rheumatic Fever _____
Epilepsy _____		Hearing Problems _____
MS _____	Other _____	Sight Problems _____
Arthritis _____	Other _____	

If YES, is student taking medication or using special equipment for any of the above: _____

***Attach specific directions for the use of prescriptions/medical equipment. Include step-by-step instructions, quantity, and the frequency of medication/equipment usage.**

If YES, are they able to properly manage the condition on their own? _____

How: _____

Does the student have any allergies to:

Aspirin _____	Penicillin _____	Animals _____
Tylenol _____	Sulfa _____	Sun _____
Ibuprofen _____	Tetracycline _____	Smoke _____
Other _____	Other _____	Other _____

Insect Stings _____

If YES, is an EpiPen required? _____ * Two epipens must be available to the student at all times/in med box/with them

Should a parent be called immediately if stung? _____ 911? _____

Special instructions: _____

Milk _____

If YES, are they able to properly manage the condition on their own? _____

How: _____

Food _____

If YES, are they able to properly manage the condition on their own? _____

How: _____

In case of an allergic reaction, what action do you wish to be taken? Please be specific:

Additional Information:

Is the student taking any medications which are 'sun sensitive'? _____ What? _____

If YES, are they able to properly manage themselves outdoors? _____ How: _____

Does the student suffer from Migraine Headaches? _____

Describe treatment: _____

Does the student wear contact lenses? _____

Does the student have any eating disorders? _____

Describe treatment: _____

Is the student a vegetarian? _____ Details: _____

Has student ever injured any of the following:

Knees _____ Back _____ Shoulders _____ Arms _____ Feet _____

Ankles _____ Neck _____ Wrists _____ Hands _____ Legs _____

Other _____

Is any special protective equipment necessary? _____

Details/special treatments: _____

Additional comments regarding the emotional and physical health of the student:

Parent Authorization: This Health History is correct to the best of my/our knowledge and the Student herein described has permission to engage in all activities, unless otherwise noted by me/us. I/we give permission to the Physician or Hospital selected by the Medical Representative of the Glenelg High School Music Department to hospitalize, secure proper treatment, and to order medications, injections, anesthesia or surgery for my/our student in my/our absence. Furthermore, I/we hereby authorize Mr. Barry Enzman, Ms. Theresa Newsome, Mrs. Dianne Bissell-Hodges, or the designated Medical Representative to act on my/our behalf in the event of a medical emergency during the period of May 1, 2008 through August 31, 2009.

Parent Signature: _____

Date: _____