

GLENELG HIGH SCHOOL MUSIC DEPARTMENT

2010 ADULT MEDICAL FORM

Name: _____
 Cell Phone: _____
 Home Phone: _____
 Address: _____
 City/State/Zip: _____
Social Security Number(Optional): _____

Insurance Company: _____
 Policy #: _____
 Address: _____
 City/State/Zip: _____

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

Emergency Contact Name: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Email: _____

Doctor's Name: _____
 Phone: _____

Dentist's Name: _____
 Phone: _____

Orthopedist's Name: _____
 Phone: _____

HEALTH HISTORY

Date of adult's most recent Tetanus Shot: _____

Please answer YES or NO to all questions.

Is adult presently taking any medication? _____

Type and frequency: _____
 Concerns: _____

Has adult had, or does adult have:

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

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

***In case of an emergency, please attach specific directions for the use of prescriptions/medical equipment.**

Include step-by-step instructions, quantity, and the frequency of medication/equipment usage.

Does the adult 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 adult at all times/in med box/with them**

If stung, is immediate action necessary? _____ 911? _____

Special instructions: _____

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

Additional Information:

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

Does the adult suffer from Migraine Headaches? _____

Describe treatment: _____

Does the adult wear contact lenses? _____

Does the adult have any eating disorders? _____

Describe treatment: _____

Is the adult a vegetarian? _____ Details: _____

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

Authorization: This Health History is correct to the best of my knowledge and the adult herein described is able to engage in all activities, unless otherwise noted. I 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 me in the event my emergency contact cannot be reached. Furthermore, I hereby authorize Barry Enzman, Theresa Newsome, Dianne Bissell-Hodges, or Marilyn Knight-Griffin to act on my behalf in the event of a medical emergency during the period of April 15, 2010 through May 15, 2010.

Signature: _____

Date: _____