Husky Band Medical Form

Student Name: _____.

Phone: (_____) _____-_____ Date of Birth: _____.

Address: _____.

City:_____ State: _____ Zip: _____.

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Parent/Guardian Name:_____.

Home Phone: (___) ___-_____ Cell: (___) ___-_____Work: (___) ___-_____.

Address: _____.

City:_____ State: _____ Zip: _____.

Email:_____.

Name emergency contact (if you are unreachable):_____.

Phone: (_____) _____-_____.

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Physician's Name: _____Phone: (___) ___-_____ .

Address: _____.

City:_____ State: _____ Zip: _____.

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Current medications the student is taking - Please list name, dose, time, and frequency:

._____.

._____.

._____.

._____.

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Student medication and/or environmental allergies/anaphylactic reactions - Please also list treatment in the event of a reaction:_____.

._____.

._____.

._____.

Health History of Student - Please list all:_____.

_____.

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_____.

_____.

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Please list any special dietary needs:_____.

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Date of last tetanus shot:_____Date of last physical:_____.
(a **copy of the student's physical** will need turned in with this medical form ASAP in order to participate in marching activities.)

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My child may take (please check):Aspirin_____, Ibuprofen_____, Tylenol_____, as administered by a chaperone.

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Please provide a copy of the student's insurance card with this form. If the parent who provides insurance is not listed on this form already, please add them and their phone number here:_____ (_____)_____-_____.

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Parent's Authorization:

This health history is correct to the best of my knowledge, and the student herein described has permission to engage in all activities, unless otherwise noted by me. I give permission to band staff/chaperones to administer first aid to my child as they see fit, and to seek additional treatment at the local hospital, or from a local physician, trusting they will notify me as soon as possible.

In the event of such a medical emergency, I hereby give permission for my child to receive medical treatment from a physician and/or other health personnel. Such treatment may include first aid, hospitalization (outpatient or inpatient), medication, injections, anesthesia, or surgery.

Signature of Parent/Guardian:_____.

Date: _____.