2017-2018 SBRHS WINTER MARCHING ARTS ENSEMBLES' HEALTH FORM

*Please be sure to fill out **ALL** information on the form! If it does not apply, please write **N/A***

Student Name: _____ Section: _____ Grade: ____

Parent/Guardian Name: _____

Address: _____ City: _____ State ____ Zip: _____

Home Telephone: _____ Business/Day Phone: _____

1. If a parent is not available in the unlikely case of an emergency, please notify: (Give two names other than parents)

   Name: _____ Name: _____

   Relationship: _____ Relationship: _____

   Phone: _____ Phone: _____

2. Physician's Name: _____ Phone: _____

3. Does your son/daughter have any **illness** that (s)he is being treated for? (Ex. Diabetes, epilepsy, asthma) Yes _____ No _____
   If yes, indicate illness: _____
   (All information given is confidential.)

   If asthmatic, does you son/daughter use an inhaler?
   Yes _____ No _____ If yes, name of inhaler: _____
   Please be sure your son/daughter has an extra inhaler. Please instruct your son/daughter to keep the inhaler with him/her at all times. The school nurse should be given the extra inhaler in case of loss.

4. Please list any **medications** your son/daughter takes on a regular basis. **(Please be sure to send it with them.)**
   Indicate below the name of the medication and the specific times of day to be taken:

   Medicine: _____

   Medicine: _____

   Medicine: _____

5. Please indicate if your son/daughter is **allergic** to the following. (Yes or No)

   Medication _____

   Insect stings _____ Food Allergy _____

   If yes, please describe the type of **reaction**, (Hives, breathing difficulties, swelling, etc.)
   _____
   Is an Epinephrine injector prescribed? (Yes or No)

6. If it is felt that your son/daughter should have the **medication** listed here, may an official chaperone administer your son/daughter the medicine according to the school physicians standing medical orders? (Yes or No)
   Tylenol _____ Ibuprofen _____ Tums _____ Cough Drops _____

7. Please indicate health insurance information:
   Name: _____
   ID Number: _____
   Subscriber's name: _____ ***(Attach a copy of card if possible)***

8. Suggestions from parents as to limitations or signs of health risks for chaperones to be aware of:
   _____
   _____

Authorization: This Health History is correct insofar as I know and the student therein described has my permission, as legal parent/guardian, to engage in all prescribed tour activities, except as noted by me in the space provided above. In the event that I or the individuals listed above for emergency notification cannot be reached in an "emergency", I hereby give my permission to the physician selected by Mr. David M. Marshall to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my son/daughter as named above.

Parent/Guardian Signature: _____ Date: _____

RETURN THIS FORM TO MR. MARSHALL BY MONDAY, DECEMBER 4, 2017