

2019-2020 SBRHS "BLUE RAIDER" MARCHING BAND 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 JUNE 18, 2019