Medical Information Form 2018-2019 Tate High School Band

Students Name:_____
Last First MI

Date of Birth:_____ Age:_____Grade:_____ Band____Jazz____Guard____Percussion____

Parents/Guardians Name	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Address:_____
(Street) (City) (Zip)

Child lives with: (circle one) Both Parents Mom Dad Other:_____

Email Address:_____

In case of Emergency and you cannot be reached, who do you authorize to take your child home in case of illness?

Name	Relation	Contact Numbers
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History: List any of your child's health problems or conditions. If they have none, write N/A

___Medication Allergies_____
(treatment if exposed)_____
___Insect Allergies_____
(treatment if exposed) _____
___Food Allergies_____
(treatment if exposed)_____
___Other Allergies_____
(treatment if exposed)_____
___Vision/Hearing/Speech Problem_____
___Other specific problems not otherwise noted_____
_____
___My child takes the following medication on a routine or as needed basis. (Please list purpose of medication)
_____
_____

Please indicate below which medications from our medical kit that we may give or use on your child while attending a Tate Band function. (Generic brands may be substituted) By filling out this section and signing below, you are giving permission for the designated medical person to administer the checked medications to your child during a Tate Band activity. ***In the event that a prescription or non-prescription medication (not listed below) is to be administered you must get an "Authorization for Administration for Prescription Medication" form from your doctor's office and ensure that the doctor signs each form*.** There must be a separate form for EACH medication. Medication must be in the original pharmacy labeled container. No medications will be allowed to be transported or taken by a student during a band activity unless administered by a medical chaperone.

__Acetaminophen(Tylenol)__Calcium Carbonate(Tums/Malox)__Diphenhydramine(Benadryl__Ibuprofen(Motrin/Advil)

Date:_____ Parent/Guardian's Signature_____

Medical Insurance Information:

Name of Medical Insurance_____ _Policy#_____Phone#_____
Policy Holders Name_____Employer_____
Family Doctor's Name_____Phone #_____
Hospital Choice_____