MILLERSBURG MARCHING BAND MEDICAL FORM
MILLERSBURG AREA SCHOOL DISTRICT
STUDENT MEDICAL INFORMATION

STUDENT NAME _____ DATE _____

GENDER_____ AGE _____ BIRTHDATE _____ GRADE_____

HOME ADDRESS _____

_____

HOME PHONE _____

FATHER'S FULL NAME _____

CELL PHONE _____WORK PHONE _____ HOURS _____

MOTHER'S FULL NAME _____

CELL PHONE _____WORK PHONE _____ HOURS _____

STEP PARENT OR GUARDIAN _____

CELL PHONE _____WORK PHONE _____ HOURS _____

IS THE STUDENT CURRENTYLY UNDER ANY MEDICAL TREATMENT? Yes No

IF YES, PROVIDE DETAILS:

_____

IS THE STUDENT CURRENTLY TAKING ANY MEDICATION? Yes No

IF YES, GIVE THE NAME OF THE MEDICATION, AND REASON IT IS GIVEN:

_____

LIST YOUR CHILD'S MAJOR CONDITIONS OF WHICH THE SCHOOL NURSE OR DIRECTOR SHOULD BE MADE AWARE (example: EPILEPSY, HEAT CONDITION, DIABETES, ETC.)

_____

LIST ANY ALLERGIES YOUR CHILD EXPERIENCES:

_____

IF ALLERGIES EXIST, WILL ANY CAUSE ANAPHYLAXIS? Yes No

DATE OF LAST TETANUS SHOT: _____

NAME OF HEALTH INSURANCE _____

NAME OF GUARANTOR _____ POLICY #: _____

FIRST AID/MEDICAL EMERGENCY AUTHORIZATION

If the school or director successfully contact the parent/guardian, please list one relative or friend who would have the authority to advise us regarding your child:

Name _____ Relationship to child _____

Home Phone _____ Cell Phone _____ Work Phone _____

If none of the above can be reached by phone, WHAT DO YOU WISH THE SCHOOL OR DIRECTOR TO DO in case the child is sick or injured?

_____

_____

PARENTAL CONSENT: As parent(s)/guardian(s) of the student listed on this form, I/we give permission for my/our child to receive first aid for illness or injuries. I/we authorize emergency care in the event I/we cannot be contacted. I/we authorize medical information to be shared by the director with medical personnel and/or his/her responsible adult designee involving my/our child as needed. I/we understand that I/we will be contacted at my/our place of employment by the director should it be necessary for my/our child to go home due to illness or injury. I/we will provide recommendations in writing from a physician if my/our child is restricted from participation in physical education classes, school sports, band, or other activities.

Hospital of Choice_____

Doctor of Choice_____

If at any time the above information must be changed, I will notify my child's music director and/or school district administration in writing.

_____ _____

Signature of parent or guardian Date

School term: 20 ___ - 20 ___