

MEDICAL INFORMATION

PENNCREST HIGH SCHOOL BAND

Student Name: _____ Date _____
(Last) (First)

Address: _____ Date of Birth: _____

Parent or Guardian Name: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Contact Name: _____ Phone: _____

Insurance company _____ Policy number _____

Health History: (Check)

- Diabetes
- Orthopedic Problems
- Asthma
- Epilepsy
- Cardiac Problems
- Migraines

Allergies: (Check)

- Aspirin
- Penicillin
- Sulfa
- Insect Stings
- Tetracycline
- Food Allergy (Specify _____)

Other (Specify _____)

Do we have permission to administer the following to your child? (Check)

- | | |
|-------------------------|-------------------|
| Acetaminophen (Tylenol) | Ibuprofen (Advil) |
| Sudafed | Dramamine |
| Benadryl | |

Has your child had a tetanus shot current to within six years? Yes No

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? Explain.

Does your child have permission to use a pool? Yes No

(Swim areas may not be staffed by lifeguards. Trip participants swim at their own risk)

Please list any medications your child is currently taking or will be bringing:

Prescription medications must be kept by a chaperone, with the exceptions of epi-pens, inhalers, and insulin pumps.

I give permission to the physician or hospital to secure proper treatment for and to order medications, injections, anesthesia or surgery for my child as named above. I also understand that this medical information will be used on all music department functions throughout the year. If there are any additions or changes, I will notify the director in writing. I give permission for my child's medical information to be shared with the director, chaperones, and medical personnel if necessary, under HIPAA regulations.

Signature of Parent of Guardian

Date