#15

**FSHS POLAR BEAR BAND**
**STUDENT MEDICAL FORM**
**2019-2020**

**STUDENT NAME** :_____________________________________________ PHONE: ______________________________

ADDRESS: _____________________________________ CITY:_______________________ STATE________ ZIP __________

DOB:___________________ STUDENT GENDER: (circle one) M F

**PARENT/GUARDIAN NAME**: __________________________________________________________

EMPLOYER: ________________________________________________ WORK PHONE: ________________________

HOME PHONE: _______________________________ CELL PHONE: _______________________________

**PHYSICIAN'S NAME**: __________________________________________ PHONE: _____________________________

**EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED**

NAME: __________________________________ Relationship ____________________ PHONE: _____________________

**CURRENT MEDICATION(S) STUDENT IS TAKING:**

____________________________________________________________________________________________________

**ALLERGIES/ANAPHYLACTIC REACTIONS:** ______________________________________________________________

____________________________________________________________________________________________________

Please indicate allergy and treatment in the event of an allergic reaction. (Send medication with student, i.e. inhaler, EpiPen, etc).

**CHRONIC CONDITIONS**: (Please list any chronic conditions to which your child may be subject.):

____________________________________________________________________________________________________

**HEALTH HISTORY: (Check all that apply)**

_____ Diabetes
_____ Orthopedic Problems
_____ Asthma
_____ Epilepsy
_____ Cardiac Problems
_____ Other - Please list: _______________

**MEDICATION ALLERGIES: (Check all that apply)**

_____ Aspirin
_____ Penicillin
_____ Sulfa drugs
_____ Tetracycline
_____ Doxycycline
_____ Insect Stings/Bites
_____ Other medications/specify:___________________

**DATE OF LAST TETANUS SHOT:** ______________________

**My child may take: Aspirin _____ Tylenol _____ Ibuprofen _____ Benadryl ______ as administered by chaperones.**

**My child may take their prescription medications as administered by _____ Mr. Schneider and/or _____Chaperone**

**INSURANCE -** My child is _____ is not _____ covered by a medical insurance plan.

Name of parent who provides insurance coverage: ______________________________________________

NAME OF INSURANCE COMPANY: _______________________________________________________

ADDRESS: ____________________________ CITY: _____________ STATE: _______ ZIP : _________

PHONE: ___________________ POLICY #: ____________________ GROUP #:________________

**PARENT'S AUTHORIZATION**

This health history is correct to the best of my knowledge, and the student herein described has permission to engage in all activities, unless otherwise noted by me. I give permission to band staff/ chaperones to administer first aid to my child as they see fit, and to seek additional treatment at the local hospital, or from a local physician, trusting they will notify me as soon as possible.

In the event of such a medical emergency, I hereby give permission for my child to receive medical treatment from a physician and/or other health personnel. Such treatment may include first aid, hospitalization (outpatient or in-patient), medication, injections, anesthesia, or surgery.

_____________________________________________ _________________________
(Signature of Parent/Guardian) (Date)

**Please return this form by 05/28/2019**