

GRASSFIELD HIGH SCHOOL BAND PROGRAM MEDICAL FORM

PLEASE PRINT - ALL SPACES MUST BE FILLED IN- IF NOT APPLICABLE, WRITE "NONE" IN SPACE PROVIDED

STUDENT NAME _____

GRADE _____ INSTRUMENT PLAYED or GUARD _____

DOB ____/____/____ STUDENT CELL PHONE (757) _____

MOTHER NAME _____ FATHER NAME _____

MOTHER HOME# _____ FATHER HOME# _____

MOTHER CELL# _____ FATHER CELL _____

MOTHER ADDRESS _____

FATHER ADDRESS _____

EMAIL ADDRESS(ES) _____

2 EMERGENCY CONTACTS MUST BE AVAILABLE: IN CASE OF EMERGENCY, PLEASE NOTIFY

NAME _____

RELATIONSHIP _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

NAME _____

RELATIONSHIP _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

FAMILY DOCTOR _____

PHONE (757) _____

ADDRESS _____

HEALTH INSURANCE CARRIER COVERING STUDENT

POLICY NUMBER _____ GROUP NUMBER _____

DOES STUDENT CARRY POLICY ID CARDS ----YES----NO **PLEASE ATTACH COPY OF CARD.**

DESCRIBE ANY HISTORY OF SERIOUS ILLNESS, SURGERIES, INJURIES, OR CHRONIC CONDITIONS: I.E., DIABETES ETC.

LIST ALL MEDICATIONS TAKEN ROUTINELY OR THAT MAY NEED TO BE TAKEN DURING BAND FUNCTIONS

DATE OF LAST TETANUS IMMUNIZATION ____/____/____

DOES STUDENT WEAR CONTACT LENSES ----YES----NO

GLASSES ----YES----NO

HEARING DEVICE----YES----NO

ASTHMA INFORMATION!

HAS YOUR CHILD EVER HAD AN ASTHMATIC ATTACK ----YES----NO DATE OF LAST ATTACK _____

IF YOUR CHILD HAS EVER HAD AN ATTACK IT IS MEDICALLY REQUIRED THAT HE/SHE CARRY AN INHALER AT ALL TIMES

DOES YOUR CHILD CARRY AN INHALER? ----YES---NO

ALL ASTHMA STUDENTS MUST HAVE AN INHALER AT ALL TIMES WITH THEM. NO INHALER, NO PARTICIPATION IN BAND ACTIVITIES!

ALLERGIES

DOES YOUR CHILD HAVE ALLERGIES? YES NO

IF YES, PLEASE LIST ANY ALLERGIES: _____

DOES YOUR CHILD HAVE A EPI-PEN? YES NO

PLEASE LIST WHY? _____

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS TAKING: _____

“I HEREBY AGREE THAT ANY TRAINED BAND PARENT SERVING IN THE CAPACITY OF CHAPERONE MAY ADMINISTER THE OVER-THE-COUNTER MEDICATIONS IDENTIFIED BELOW TO THE NAMED STUDENT.”

PLEASE CIRCLE ANY MEDICATION YOU WISH TO ALLOW NAMED STUDENT TO RECEIVE

TYLENOL *OR GENERIC EQUIVALENT (OGE)*

ADVIL *OGE*

OTHER SPECIFIC MEDICATION CARRIED BY STUDENT _____

PARENTS OF MINORS: “I HEREBY AGREE THAT MEDICAL PERSONNEL MAY ADMINISTER FIRST AID TREATMENT AS NEEDED TO THE ABOVE NAMED STUDENT IN CASE OF EMERGENCY AND/OR REFER AND/OR TRANSPORT NAMED STUDENT TO A LOCAL CLINIC OR HOSPITAL FOR TREATMENT”

“I ALSO HEREBY AGREE THAT ANY TRAINED BAND PARENT SERVING IN THE CAPACITY OF CHAPERONE MAY ADMINISTER THE OVER-THE-COUNTER MEDICATIONS IDENTIFIED ABOVE TO THE NAMED STUDENT.”

SIGNATURE OF PARENT OR LEGAL

GUARDIAN _____

REQUIRED DATE ____/____/_____

COMMONWEALTH OF VIRGINIA, CITY OF CHESAPEAKE, TO-WIT:

THE FOREGOING INSTRUMENT WAS SUBSCRIBED BEFORE ME THIS ____ DAY OF 20__

BY _____ . MY COMMISSION EXPIRES: _____ .

RAISED SEAL OF NOTARY