**Health Form**

Hamilton Southeastern High School Band Department

**To be completed by Parent or Guardian**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | | Click here to enter text. | | | First Name: | | Click here to enter text. | |
| Date of Birth: | | | Use format mm/dd/yyyy | Height: | | Click here. | Weight: | Click here. |
| Address: | Click here to enter street, city, state, zip | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Parent/Guardian #1: | | Enter first & last names here. | | Parent/Guardian #2: | | Enter first & last names here. | |
| Home Phone: | Click here. | | Cell #1: | Click here. | Cell #2: | | Click here. |

If those listed above are ***not*** available, in the event of an emergency please notify:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | Enter first & last names here. | | | | | Phone: | Click here. | |
| Relationship: | | Click here. | | | | Cell: | Click here. | |
| Physician’s Name: | | | | Enter first & last names here. | | Physician’s Phone: | Click here. | |
| Health/Accident Insurance: | | | | | Click here. | If NO insurance, check here: | |  |
| Policy Number: | | | Click here. | | | Group Number: | Click here. | |

Medical Information (please check):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Asthma: | Yes  No | Diabetes: | | Yes  No | | Seizures: | Yes  No |
| Allergies: | Yes  No | Hemophilia: | | Yes  No | | Heart Condition: | Yes  No |
| Physical or Emotional Restrictions: | | | Yes  No | | Any other Medical Concerns: | | Yes  No |

If you checked “Yes” anywhere above, please provide an explanation of each below so that we may provide safe participation (attach separate document if more space is required):

|  |
| --- |
| Click or tap here to enter text. |

Please provide date of most recent Tetanus/Tdap vaccine. *Note: the Tdap is one of the required 6th grade vaccines.* **Tetanus/Tdap Vaccine Date:** Click or tap here to enter text.

Parent Signature: Date:

**AUTHORIZATION TO GIVE MEDICATION**

Please list any prescription medication (including inhalers and epi pen) taken by the student.

|  |  |
| --- | --- |
| Medication and Reason | Dosage, Date, and Times |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

Other than an inhaler or epi pen, will your student be taking any of the above listed medications while at any band activity? *Note: Refrigeration is not available, therefore parents must be responsible for transporting medication that require refrigeration.*  Yes  No

Will your child be carrying their inhaler or epi pen and assume responsibility for their emergency medications during the band season?  Yes  No

Will you be providing and inhaler or epi pen to be kept in the band medical box during the band season for your child’s use if needed?  Yes  No

May your student be given the following over-the-counter medications when needed?

|  |  |  |  |
| --- | --- | --- | --- |
| * Acetaminophen/Tylenol | Yes  No | * Cough Drops | Yes  No |
| * Ibuprofen/Motrin/Advil | Yes  No | * Benadryl | Yes  No |
| * Antibiotic Ointment | Yes  No | * Pepto Bismol/Antacid | Yes  No |

This form must be signed by the parent before the above medications can be given by a volunteer chaperone during band activities.

Parent/Guardian Signature: Date:

MEDICAL AUTHORIZATION AND RELEASE: In the event my child requires immediate or emergent medical care, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby authorize the HSE High School band directors and/or the adult chaperones that are in charge to transport my child to a qualified health care provider, provide emergency first aid, or to otherwise seek professional medical care for my child as they deem appropriate. I also authorize the health care provider who treats my child to provide my child with any medical treatment that he or she deems necessary or advisable under the circumstances, including but not limited to, hospitalization, anesthesia, surgery, medication and emergent care. I understand that the Hamilton Southeastern High School band department, band directors, chaperones and volunteers are not responsible for any improper medical care rendered to my child, or for any medical expenses incurred on behalf of my child.

Parent/Guardian Signature: Date: