Crockett High School Band Confidential Medical Form

Student Name: ______________________ Birthdate: __________ Section: ______________
Last First mm/dd/yyyy

Current Address: ____
Street Address House/Apt# City Zip

Mother/Guardian #1 Name: ______________________ Landline Phone: ______________

Email: ______________ Work Phone: ______________ Cell Phone: ______________

Father/Guardian #2 Name: ______________________ Landline Phone: ______________

Email: ______________ Work Phone: ______________ Cell Phone: ______________

Student Email: ______________________ Student Cell Phone: ______________

In the event a parent/guardian cannot be reached, who should be contacted in case of an emergency?

Name: ______________________ Relation: ______________ Phone: ______________

Name: ______________________ Relation: ______________ Phone: ______________

Insurance Carrier: ______________________ **Policy Number:** ______________

Group Number: ______________________ **Insurance Contact Number:** ______________

Doctor's Name: ______________________ **Doctor Contact Number:** ______________

Is there any additional information we should know? Please use the back of this sheet to explain.

List ALL known allergies – including medications, food, animals, bites, stings, dust, pollen, etc.

ALLERGY	REACTION	TREATMENT REQUIRED

List ALL known conditions including asthma, diabetes, low blood sugar, blood pressure, etc.

CONDITION	TREATMENT	MEDICATION REQUIRED

List ANY additional medications being used by student:

Crockett High School Band Medical Attention Release

Student Name: ______________________________

I give permission for the Crockett Band Directors or their designees the authority to seek medical attention for the above named student to administer the following over-the-counter medications as needed.

Please circle YES or NO for each medication listed:

Ibuprofen	YES	NO
Acetaminophen	YES	NO
Cough Syrup	YES	NO
Oral Antihistamines	YES	NO
Topical Antihistamines	YES	NO
Pepto Bismol	YES	NO
Tums	YES	NO
Bug Spray (containing Deet)	YES	NO

I understand that in the event that a parent or guardian cannot be reached or immediate attention is required, the CHS Band or any of its designated volunteers has my permission to seek appropriate medical attention. It is the parent's/guardian's responsibility to update this record if necessary.

Parent/Guardian 1 Signature ______________________________________ **Date** __________

Parent/Guardian 2 Signature ______________________________________ **Date** __________