

BRADLEY CENTRAL HIGH SCHOOL BAND

STUDENT MEDICAL FORM

NAME _____ AGE _____

ADDRESS _____ CITY _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

PARENT/GUARDIAN NAME _____

HOME PHONE _____ WORK PHONE _____

DOES STUDENT HAVE INSURANCE THROUGH PARENT EMPLOYER? _____

IF YES, NAME OF INSURANCE COMPANY _____

POLICY # FOR ABOVE _____

HEALTH HISTORY-- CHECK IF APPLICABLE

- _____ DIABETES
- _____ ORTHOPEDIC PROBLEMS
- _____ ASTHMA
- _____ EPILEPSY
- _____ CARDIAC PROBLEMS
- _____ OTHER HEALTH PROBLEMS
(EXPLAIN BELOW)

ALLERGIES - CHECK IF APPLICABLE

- _____ ASPIRIN
- _____ PENICILLIN
- _____ SULFONAMIDE
- _____ INSECT BITES/STINGS
- _____ TETRACYCLINE
- _____ OTHER ALLERGY
(EXPLAIN BELOW)

OTHER HEALTH PROBLEMS (EXPLAIN)

OTHER MEDICINAL ALLERGY (EXPLAIN)

DO WE HAVE PERMISSION TO ADMINISTER THE FOLLOWING PAIN RELIEVERS TO YOUR CHILD?

_____ASPIRIN _____ ACETAMINOPHEN (TYLENOL) _____IBUPROPHEN (ADVIL)

HAS YOUR CHILD HAD A TETANUS SHOT CURRENT WITHIN THE LAST 6 YEARS? _____ (Y/N)

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? IF YES, PLEASE EXPLAIN. MENTION ANY RECENT SURGERY, ILLNESS, BROKEN BONES, INJURIES, AND ALLERGIES OTHER THAN MEDICATION OR OTHER PHYSICAL CONDITIONS. (ON BACK OF FORM)

PARENT AUTHORIZATION: THIS HEALTH HISTORY IS CORRECT TO THE BEST OF MY KNOWLEDGE AND THE STUDENT DESCRIBED HAS PERMISSION TO ENGAGE IN ALL ACTIVITIES, UNLESS OTHERWISE NOTED BY ME. I GIVE PERMISSION TO THE PHYSICIAN OR HOSPITAL SELECTED BY A MEDICAL REPRESENTATIVE OF MY SON OR DAUGHTER'S SCHOOL TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER MEDICATIONS, INJECTIONS, ANESTHESIA, OR SURGERY FOR MY CHILD AS NAMED ABOVE.

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____