

HEALTH FORM

RETURN **ASAP** TO NWHS MUSIC DEPARTMENT

Students will not be allowed to participate in marching band with an incomplete form!

Student Name: _____ Date of Birth: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Pager: _____
Father's Name _____ Work Number: _____
Mother's Name _____ Work Number: _____
Emergency Contact Person
Name _____ Relationship _____
Phone Number: _____
Doctor _____ Phone _____
Insurance Company _____ Policy # _____
Name of Insured _____ Group # _____
Insurance Company Phone # _____

Does your child have any pre-existing conditions that could affect their ability to participate in marching band activities? Yes ___ No ___
If yes, please explain:

Does your child require any medical treatments, such as inhalers, nebulizers, glucose monitoring? Yes ___ No ___ If yes, please list the treatment, frequency and times needed.

Does your child have any allergies to food, medication or other substances? Yes ___ No ___
If yes, please list the allergen and their specific reaction.

The above needs to be addressed with you and your doctor. It is the responsibility of the parent and child to be prepared during rehearsals and scheduled activities. (i.e. inhalers, etc. must be provided by and kept with the child). Any emergencies that may arise will be handled.

Does your child take any medication: Yes ___ No ___
This includes both prescription medications as well as over the counter medications (such as Tylenol, Advil, Benadryl, etc.)
If yes, please list the name of the medication, the dose, when taken and why they take it.

Date of last tetanus shot? _____

I give permission for immediate medical treatment as required in the judgement of the attending physician. Notify me as soon as possible.

Signed _____ Date _____

I DO NOT give permission for medical treatment until I have been contacted.

Signed _____ Date _____