Health History Form - 2016

To be completed annually by parent/guardian. This form is confidential and to be kept with the individual's records.
This information is requested on an annual basis so we can best take care of your student and ensure safety.

Student Information:

Name (Last, First): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Information:

Parent/Guardian Name: _____

Phone (day) _____ Phone (evening) _____ Cell _____

Email: _____

Parent/Guardian Name: _____

Address (if different than student) _____

Phone (day) _____ Phone (evening) _____ Cell _____

Email: _____

Emergency Contact Information:

In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

Name: _____ Relationship to Participant: _____

Phone (day) _____ Phone (evening) _____ Cell _____

Health Care Information:

Physician's Name: _____ Phone _____ Last Exam Date: _____

Address _____ City _____ State ___ Zip _____

Do you carry family medical/hospital insurance? ❑ Yes ❑ No If yes, please complete the following information.

Insurance Company: _____ Policy/Group # _____

Through (employer): _____ Insured Name (parent) _____

Health History: *Check those that apply. Add dates and comments below for any checked items. Feel free to add information on back of form or attach additional sheet(s) to fully explain if needed.*

☐ **No Known Allergies**	☐ Animals _____	☐ Food _____
☐ Hay Fever _____	☐ Insect Stings _____	☐ Medicine/Drugs _____
☐ Plants _____	☐ Pollen _____	☐ Other _____
☐ Wears glasses or contact lenses	☐ Arthritis	☐ Heart Disease
☐ Prescribed Medication	☐ Abnormal Blood Pressure	☐ Intestinal Disorders
☐ Activities to be restricted	☐ Diabetes	
☐ Asthma	☐ Disability	☐ Special Dietary Regimen

Please list any medications taken on a regular basis: _____

_____

_____

_____

_____

_____

Immunization Status (Indicate Date): o Tetanus _____ o Hepatitis B _____ o TB _____

Additional information on back? ☐ Yes ☐ No

Consent and Permission to Treat

I understand that participation in Marching Band, Winter Guard and Winter Drumline involves some element of risk, but that the Mt. Pleasant Public School (MPPS) staff and the Instrumental Music Boosters (IMB) will make every effort to avoid such risk to my child. In the event of an emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby authorize a representative of MPPS or IMB to act on my behalf to seek medically necessary treatment until I can be reached. I absolve MPPS, IMB and their representatives from liability in acting on my behalf in this regard so long as MPPS and IMB are not grossly negligent.

Parent/Guardian Signature: _____ Date: _____