

Health History Form - 2017

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.

- | | | |
|--|--|--|
| <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Insect Stings _____ | <input type="checkbox"/> Medicine/Drugs _____ |
| <input type="checkbox"/> Plants _____ | <input type="checkbox"/> Pollen _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Wears glasses or contact lenses | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Prescribed Medication | <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Intestinal Disorders |
| <input type="checkbox"/> Activities to be restricted | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Disability | <input type="checkbox"/> Special Dietary Regimen |

Please list any medications taken on a regular basis: _____

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