

**DEEP CREEK HIGH SCHOOL BAND PROGRAM  
2008-2009 MEDICAL HISTORY AND RELEASE FORM**

**PLEASE PRINT - ALL SPACES MUST BE FILLED IN- IF NOT APPLICABLE, WRITE "NONE" IN SPACE PROVIDED**

STUDENT NAME \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ STUDENT CELL PHONE (757) \_\_\_\_\_

PARENT/GUARDIAN NAME (S) \_\_\_\_\_

HOME PHONE (757) \_\_\_\_\_ WORK PHONE (S) (757) \_\_\_\_\_

PARENT/GUARDIAN CELL PHONE (S) (757) \_\_\_\_\_ (Mother) &/or \_\_\_\_\_ (Father)

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**2 EMERGENCY CONTACTS MUST BE AVAILABLE: IN CASE OF EMERGENCY, PLEASE NOTIFY**

NAME \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_

NAME \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_

**HEALTH AND HEALTHCARE INFORMATION**

FAMILY DOCTOR \_\_\_\_\_

PHONE (757) \_\_\_\_\_ ADDRESS \_\_\_\_\_

**HEALTH INSURANCE CARRIER COVERING STUDENT**

POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

DOES STUDENT CARRY POLICY ID CARDS ----YES----NO **PLEASE ATTACH COPY OF CARD.**

**DESCRIBE ANY HISTORY OF SERIOUS ILLNESS, SURGERIES, INJURIES, OR CHRONIC CONDITIONS (I.E. DIABETES, ETC.)**

**LIST ALL MEDICATIONS TAKEN ROUTINELY OR THAT MAY NEED TO BE TAKEN DURING BAND FUNCTIONS**

DATE OF LAST TETANUS IMMUNIZATION \_\_\_\_/\_\_\_\_/\_\_\_\_

DOES STUDENT WEAR CONTACT LENSES ----YES----NO GLASSES ----YES----NO HEARING DEVICE----YES----NO

OTHER PROSTHESIS----YES----NO EXPLAIN: \_\_\_\_\_

**ASTHMA ASTHMATIC ATTACK HISTORY**

HAS YOUR CHILD EVER HAD AN ASTHMATIC ATTACK ----YES----NO DATE OF LAST ATTACK \_\_\_\_\_

**IF YOUR CHILD HAS EVER HAD AN ATTACK IT IS MEDICALLY REQUIRED THAT HE/SHE CARRY AN INHALER AT ALL TIMES**

DOES YOUR CHILD CARRY AN INHALER ----YES----NO

**ALLERGIES**

DOES YOUR CHILD SUFFER FROM SEASONAL ALLERGIES----YES----NO

MEDICATION USED OR CARRIED: \_\_\_\_\_ OR NONE

**FOOD OR OTHER ALLERGIES**

SPECIFIC SENSITIVITIES AND REACTION: \_\_\_\_\_

**DOES YOUR CHILD CARRY AN EPI-PEN----YES----NO IF YES, MUST COME WITH THEM!**

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“I HEREBY AGREE THAT ANY TRAINED BAND PARENT SERVING IN THE CAPACITY OF CHAPERONE MAY ADMINISTER THE OVER-THE-COUNTER MEDICATIONS IDENTIFIED BELOW TO THE NAMED STUDENT.” ----YES----NO

**PLEASE CIRCLE ANY MEDICATION YOU WISH TO ALLOW NAMED STUDENT TO RECEIVE**

TYLENOL OR GENERIC EQUIVALENT (OGE)

ADVIL OGE

OTHER SPECIFIC MEDICATION CARRIED BY STUDENT

\_\_\_\_\_

**PARENTS OF MINORS:** “I HEREBY AGREE THAT MEDICAL PERSONNEL MAY ADMINISTER FIRST AID TREATMENT AS NEEDED TO THE ABOVE NAMED STUDENT IN CASE OF EMERGENCY AND/OR REFER AND/OR TRANSPORT NAMED STUDENT TO A LOCAL CLINIC OR HOSPITAL FOR TREATMENT”

“I ALSO HEREBY AGREE THAT ANY TRAINED BAND PARENT SERVING IN THE CAPACITY OF CHAPERONE MAY ADMINISTER THE OVER-THE-COUNTER MEDICATIONS IDENTIFIED ABOVE TO THE NAMED STUDENT, ONLY IF CHECKED *yes ABOVE.*”

SIGNATURE OF PARENT OR LEGAL GUARDIAN

\_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

COMMONWEALTH OF VIRGINIA, CITY OF CHESAPEAKE, TO-WIT:

THE FOREGOING INSTRUMENT WAS SUBSCRIBED BEFORE ME THIS \_\_\_\_ DAY

OF \_\_\_\_\_ 2008.

BY \_\_\_\_\_ MY COMMISSION EXPIRES: \_\_\_\_\_.

**SEAL OF NOTARY REQUIRED**