

The Marlinton High School Band Medical Form

Student's Name: _____ Age: _____ Birth date: ____/____/____

Address: _____ Phone #: (____)____-_____

City: _____ Zip Code: _____ Grade : _____

Parents/Guardians Names: _____ Work #:(____)____-_____

_____ Work #:(____)____-_____

Physician: _____ Work #:(____)____-_____ Home #:(____)____-_____

Dentist: _____ Work #:(____)____-_____ Home #:(____)____-_____

Preferred Hospital: _____ Social Security No. _____-____-_____

Insurance Carrier: _____ Group #: _____

Last Physical Check-up: ____/____/____ Last Tetanus Shot: ____/____/____

May a non-aspirin pain reliever be given to your child? Yes No _____
(Signature)

Allergies

Reactions

Medication: _____

Food: _____

Animal: _____

Insect: _____

Plant: _____

Other: _____

Have you been in the hospital within the last year? Yes No Date: ____/____/____

Reason: _____

Have you ever broken any bones? Yes No Date: ___/___/___ Where: _____

Date: ___/___/___ Where: _____

Do you have any known medical conditions? Yes No Condition: _____

Do you have Hay Fever? Yes No Treatment: _____

Do you have asthma? Yes No Treatment: _____

Are you being treated for any illness at this time? Yes No

Condition: _____ Treatment/Medication: _____ Dosage _____

Condition: _____ Treatment/Medication: _____ Dosage _____

Condition: _____ Treatment/Medication: _____ Dosage _____

Medications will be distributed by a teacher or chaperone at the designated time and dosage. Students are not to carry any medicine unless it has been cleared through the school prior to this form. The students are responsible to ask for their medication.

Medical Authorization

This form allows for the emergency treatment of students who become ill or injured while under school authority when Parents/Guardians cannot be reached.

***Please fill out only section 1 to give consent,
or section 2 to refuse consent***

Section 1 Consent to treat the student

In the event that reasonable attempts have been made to contact me at (____)____-____ or (____)____-____ have been unsuccessful, I hereby give my consent for 1.) the administration of any treatment deemed necessary by Dr. _____(physician) or by Dr. _____ (dentist), or in the event that these doctors cannot be reached, by another licensed physician or dentist; 2.) the transfer of my the student to _____ Hospital or any hospital which is reasonably accessible.

This authorization does not cover major medical surgery unless on the opinion of 2 other licensed physicians or dentists, concurring on the necessity of the surgery, are obtained before the surgery is performed.

_____/____/____
Signature Date

Section 2 Refusal of consent

I do not give my consent for the emergency medical treatment of the student. In case of injury or illness requiring emergency medical treatment, I wish the school authorities to take no action but to:

_____/____/____
Signature Date