ARLINGTON HIGH SCHOOL BAND
2017-2018 HEALTH FORM

Student Name_____ Birth Date ____/____/_____
Last First MI
Address_____
(Number & Street- City- State- Zip)
Home Phone_____ Social Security # _____

Grade in School for 2017-2018_____ ☐**Marcher** ☐**Non-Marcher** (guard/pit)
Marching Instrument: _____

EMERGENCY NOTIFICATION

Father's Name _____ Home Phone _____
Father's Work # _____ Cell Phone # _____
Mother's Name _____ Home Phone _____
Mother's Work # _____ Cell Phone # _____

ALTERNATE EMERGENCY NOTIFICATION

The following persons are authorized to act in my behalf if I cannot be reached in the event of an emergency.

(1) Name _____Relationship _____

Phones: Home _____ Work _____ Cell _____

(2) Name _____Relationship _____

Phones: Home_____ Work_____Cell_____

PHYSICIAN INFORMATION

Physician's Name _____

Address_____

Cit_____State_____ Zip _____

Office Number_____ Answering Service #____

THE INFORMATION FURNISHED ON THIS FORM IS ACCURATE. I/WE, the undersigned, being the parent, legal next of kin, or legal guardian hereby authorize any necessary medical treatment for _____ while he/she is participating with THE ARLINGTON HIGH SCHOOL BAND. I also guarantee payment of all charges incurred during this medical treatment (physician, hospital, x-ray, lab, medication, ambulance, etc.) I/WE have read and understand all requirements for a student to participate in the AHS Marching Band (as outlined in the CONTRACT COMMITMENT – MARCHING SCHEDULE) and are committed to fulfilling ALL requirements for participation in the marching program. We understand that this form MUST be notarized and a copy of the FRONT and BACK of the INSURANCE CARD attached before it is returned so that the band participant may practice/march/perform with the band.

_____
Signature of Parent / Legal Guardian

_____ _____
Date Notarized **Signature of Notary Public**

HEALTH INFORMATION

_____ Allergic to Bee Stings
_____ Asthma (Will bring inhaler to all activities)
_____ Allergic to Penicillin

_____ Epi-Pen in First Aid Box

_____ Allergic to _____

_____

Date of last Tetanus shot: _____/ _____ /
Parent Special Instructions: _____

_____
_____
_____

Are you currently taking any prescription medication on a regular basis? _____ Yes _____ No
If yes, answer the following: **MEDICATION: DOSAGE -WHEN TAKEN- FOR**

_____ _____ _____
_____ _____ _____

Does student wear: ☐Eyeglasses ☐Contact Lenses Does student smoke cigarettes? ☐Yes ☐No

MEDICAL HISTORY: Place an "X" next to any of these illnesses you have had or are prone to have:

_____Eczema	_____Measles	_____Rheumatic Fever	_____Heat Stroke
_____Hives	_____Mononucleosis	_____Nervous Exhaustion	_____Heat Exhaustion
_____Bronchitis	_____Mumps	_____Tonsillitis	_____Dehydration
_____Diverticulitis	_____Chicken Pox	_____Epilepsy	
_____Hemorrhoids	_____Polio	_____Diabetes	
_____Hernia	_____Hepatitis	_____Asthma (If yes, make sure you have filled out the top box)	

We must have an inhaler for your student at all activities

Any other serious illnesses or operations you have had:

Place an "X" next to any of these symptoms you may have, either sometimes or frequently:

Nose and Throat	Head and Neck	Mouth	Cardiovascular
____Congested nose	____Frequent headaches	____Dental problems	____High blood pressure
_____Runny nose	____Neck pains & swelling	____Itching or burning	____Racing heart

PLEASE LABEL ANY MEDICATION THAT IS SENT TO CAMP (AND GAMES / TRIPS) IN A ZIPLOCK BAG WITH STUDENT'S NAME, MEDICATION NAME, AND HOW IT IS TO BE ADMINISTERED.

INSURANCE COMPANY _____
Policy Number_____ Name of Insured _____
Insurance Company Address_____
Group Holder _____

**** Attach Photocopy of Insurance card Both Front and Back ****

Our son/daughter may be given the following medication if he/she requests or if the chaperones deem necessary:
_____ Cough Syrup - Brand Name(s)_____
_____ Decongestant - Brand(s)_____
_____ Nausea Medicine - Brand(s)_____
_____ Allergy Medicine - Brand(s) _____

Headache, Pain, and Fever Medicine... Please mark how many for each.					
	Aspirin	☐ 1	☐ 2	☐ 3	☐ NONE
	Non-Aspirin (such as Tylenol)	☐ 1	☐ 2	☐ 3	☐ NONE
	Ibuprofen (such as Advil)	☐ 1	☐ 2	☐ 3	☐ NONE
	Other (please specify)				

I GRANT PERMISSION FOR ZACHARY CORPUS, TIM SIMPSON, OR THEIR REPRESENTATIVE(S) TO OBTAIN NECESSARY MEDICAL TREATMENT FOR MY SON / DAUGHTER AS DEEMED NECESSARY.

PARENT / LEGAL GUARDIAN SIGNATURE_____**DATE**_____