

2010-2011 Atlee Raider Band Medical Form

Student Name _____
Last
First
Middle

Age _____ Date of Birth _____ Student Social Security Number _____

Address _____
Street & Number
City
Zip

Parent/Guardian Names & Address

Mother's Name
Address
City
Zip

Mother's Home Phone
Work Phone
Cellular
Pager

Mother's Social Security Number _____

Father's Name
Address
City
Zip

Father's Home Phone
Work Phone
Cellular
Pager

Father's Social Security Number _____

Emergency Contact (Other than parent or guardian)

Name
Address
City
Zip

Home Phone
Work Phone
Cellular
Pager

Student's Doctor _____
Name
Office Phone
Answering Service Phone

Allergies Drug _____ Food _____ Insect Stings _____

Does student carry an "Epi Pen" or inhaler? _____
Name
Dose

Describe reaction and treatment for allergy.

Date Last Tetanus Shot _____

Check if your student has any of the following.

- | | | |
|-----------------|------------------------------|---------------------|
| Asthma _____ | Chronic Ear Infections _____ | Heart disease _____ |
| Diabetes _____ | Learning Disabilities _____ | ADD _____ |
| Seizures _____ | Orthopedic Conditions _____ | Migraines _____ |
| Arthritis _____ | Thyroid Disorders _____ | Fainting _____ |

Describe their conditions, reactions and treatments in space below.

Surgeries, Hospitalizations or Other Serious Injuries/ Conditions Not Listed Above

Medications Taken

Name	Dose	Frequency of administration	Reason for taking
Name	Dose	Frequency of administration	Reason for taking
Name	Dose	Frequency of administration	Reason for taking
Name	Dose	Frequency of administration	Reason for taking
Name	Dose	Frequency of administration	Reason for taking
Name	Dose	Frequency of administration	Reason for taking

List over the counter medicine if you allow your student to receive it from a band parent. The medical kit typically contains Tylenol, Advil, Anti Acids Benadryl, and topical creams,

_____	_____
med	dose
_____	_____
med	dose
_____	_____
med	dose
_____	_____
med	dose

ALL PRESCRIPTION MEDICATION
MUST BE LEFT WITH THE
DESIGNATED CHAPERONE DURING
OVERNIGHT TRIPS. CHAPERONE
WILL ADMINISTER MEDICATIONS
LISTED ABOVE WHEN NEEDED.

HEALTH INSURANCE

Company	Policy Number	Name of Policy Holder
_____	_____	_____

YOU ARE REQUIRED TO ATTACH A FRONT & BACK COPY OF YOUR HEALTH INSURANCE CARD TO THIS FORM

I give permission for _____ (son/daughter's name) to travel with the Atlee High School Band during the year 2010-2011. I give my consent to have my son or daughter treated should a medical emergency arise. I understand every effort will be made to contact me should an emergency arise.

Parent or Guardian Signature _____ Date _____