



# Student Information and Health Form 2009-2010 (Revised 6-12-2009)

Please provide all updated contact information for your band student and his/her parents. Medical information is kept confidential and used by the band nurses to provide medical and emergency care for your child.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Section: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

LHS Student number \_\_\_\_\_ Home Phone: \_\_\_\_\_ Student Cell: \_\_\_\_\_  
[NOT SSN]: 6 9 2 \_\_\_\_\_

Home Address: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Family home email: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

Same as

Address: above: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Employer: \_\_\_\_\_ Work telephone: \_\_\_\_\_

Work email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

Same as

Address: above: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Employer: \_\_\_\_\_ Work telephone: \_\_\_\_\_

Work email: \_\_\_\_\_

**In case of Emergency and I cannot be contacted, please contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_

HEALTH HISTORY

Student's Name: \_\_\_\_\_

Any Allergies?: **Y N** Please list: \_\_\_\_\_

Date of Last Tetanus: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Has your child ever been diagnosed with any of the following?	Diabetes: Y N	Heart Murmur: Y N	Heart Problems: Y N
	Seizures: Y N	Asthma: Y N	High Blood Pressure: Y N
	Sickle Cell Anemia: Y N	Depression: Y N	ADHD: Y N
	Migraines: Y N	Other: _____	

Past surgical history: Y N \_\_\_\_\_

Please list any medications taken by your child: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Does your child have any condition that will interfere with physical activity? Y N

Explain: \_\_\_\_\_

Doctor's name: _____	Phone #: _____
Insurance: _____	Policy Holder: _____
Group #: _____	Policy #: _____

In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be contacted, I hereby give my permission to the Physician selected by the Band Director or Band Nurse in charge to secure proper treatment, which may include hospitalization, anesthesia, surgery, or injections of medication to my son/daughter. I understand this may also include transportation to a Medical Facility or home. I understand that I will be responsible for any charges incurred in the treatment of my son/daughter under such circumstances.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for my child to be given by the Band Nurse, if needed, over-the-counter medications (ex., Tylenol, Pepto-Bismol, cold medications) and first aid for cuts, scratches, bruises, etc. I also accept full responsibility for any medications my son/daughter may take without the knowledge of the Band Nurse and relieve the school, Band Directors, and Band Nurse of any legal responsibility.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_