

Lloyd C. Bird Skyhawk Band

Medical Form 2018-19

Student Name _____
Last First Middle

Age _____ Date of Birth _____ 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

Father's Name Address City Zip

Father's Home Phone Work Phone Cellular Pager

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

Medical History

Does student have a Medical Treatment Plan on file with Chesterfield County Schools? _____

If yes, a copy must be attached to this form. Yes No

Check if your student has any of the following.

| | | |
|------------------------------|-----------------------|---------------------|
| Chronic Ear Infections _____ | Asthma _____ | Heart disease _____ |
| Learning Disabilities _____ | Diabetes _____ | ADD _____ |
| Orthopedic Conditions _____ | Seizures _____ | Migraines _____ |
| Thyroid Disorders _____ | Arthritis _____ | Fainting _____ |
| Stomach ulcers _____ | Other (specify) _____ | |

Describe their conditions, reactions and treatments in space below.

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

Date Last **Tetanus Shot** _____

Lloyd C. Bird Skyhawk Band

Medical Form 2018-19

Student Name _____
Last First Middle

Allergies

| (Circle type) | Allergy | Reaction | Treatment |
|--------------------------|---------|----------|-----------|
| Drug, Food, Insect sting | _____ | _____ | _____ |
| Drug, Food, Insect sting | _____ | _____ | _____ |
| Drug, Food, Insect sting | _____ | _____ | _____ |

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

Medications Taken

| Name | Dose | Frequency of administration | Reason for taking |
|-------|-------|-----------------------------|-------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Check "Yes" or "No" to indicate if the student may receive over-the-counter drugs from a band parent:

| Over the Counter Drug | Common uses | Yes | No |
|-----------------------|-----------------------|-----|----|
| Tylenol | pain, headache, fever | | |
| Advil | pain, headache, fever | | |
| Sudaphed | Allergy, sinus | | |
| Claritin | allergy, sinus | | |
| Cough medicine | cold | | |
| Sucrets (or similar) | sore throat | | |
| Immodium | diarrhea | | |
| Pepcid | upset stomach, nausea | | |
| Tagamet | upset stomach, nausea | | |
| Pepto Bismol | all GI complaints | | |
| Roloids (or similar) | upset stomach | | |

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 Lloyd C. Bird Skyhawk Band on all of the dates on the fall marching band calendar. 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 _____