STUDENT HEALTH HISTORY FOR
ELK GROVE HIGH SCHOOL MUSIC DEPARTMENT

Please print

STUDENT NAME_____DATE OF BIRTH _____

PARENT/GUARDIAN _____HOME PHONE # _____

ADDRESS, CITY_____, IL

BUSINESS PHONE # _____
EMERGENCY CONTACT (other than parent) _____
PHONE # _____

FAMILY PHYSICIAN _____
OFFICE PHONE # _____

HEALTH HISTORY: (please give dates where known)
COMPLETE ON ADDITIONAL PAPER IF NEEDED

_____

_____

_____

OPERATION (within last two (2) years _____ RHEUMATIC FEVER _____

EMOTIONAL PROBLEMS (i.e., hyperventilation, hysteria) _____

SERIOUS MEDICAL PROBLEMS _____ MEDICATION TAKEN _____

DIABETES _____ NAME OF INSULIN TAKEN, AMOUNT AND TIME _____

EPILEPSY _____MEDICATION TAKEN, AMOUNT AND TIME _____

TRANQUILIZERS_____ ALLERGY TO DRUGS (specify i.e. penicillin, insulin, sulfa, etc.) _____

ARE YOU PRESENTLY UNDER TREATMENT FOR ANY MEDICAL PROBLEM? _____ IF YES IDENTIFY:

PHYSICAL CONDITIONS WHICH MAY LIMIT MARCHING BAND ACTIVITIES? _____ IF YES PLEASE LIST:

PLEASE LIST ANY OTHER MEDICATIONS YOUR STUDENT IS TAKING ON AN ADDITIONAL SHEET OF PAPER.

CAN TAKE <u>AND HAVE APPROVAL TO TAKE:</u> ASPIRIN TYLENOL MOTION SICKNESS MEDICATION

DATE OF LAST TETANUS SHOT _____ SPECIAL DIETARY NEEDS? _____ PLEASE LIST:

MEDICAL RELEASE: STUDENTS COVERED BY GROUP OR OTHER MEDICAL INSURANCE AS FOLLOWS:

NAME OF INSURED _____ INSURANCE COMPANY _____

GROUP # _____POLICY # _____

ELK GROVE HIGH SCHOOL MUSIC DEPARTMENT
TRAVEL CONSENT/MEDICAL RELEASE FORM

TRAVEL CONSENT

As parent/guardian of _____, I give my permission
(name of student)
for his/her travel with the Elk Grove High School Music Department from June 15, 2014 to July 5, 2015. I am fully aware of District 214 and Elk Grove High School Music Department policies concerning student behavior and discipline, and the student for whom I am responsible has been impressed with the importance of those policies. I further agree that in the event of disciplinary action requiring my student to be returned home, I will assume the full cost of the return trip.

Date: _____Parent Signature: _____

EMERGENCY MEDICAL TREATMENT

As parent/guardian of_____, I authorize treatment
(name of student)
of the above-mentioned student by a nurse or qualified physician in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual trained in first aid, if, in the opinion of that individual, delay might endanger his/her life, cause disfigurement, physical impairment or undue discomfort. In the Medical Information portion of the form, I have listed any allergies, on-going medical treatment or medical problems which might influence treatment of the student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the under-standing that, except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

Date: _____ Parent Signature: _____