CHESTATEE HIGH SCHOOL WAR EAGLE MARCHING BAND

MEDICAL INFORMATION AND HISTORY FORM

STUDENT NAME:_____

STUDENT PHONE NUMBER:_____

STUDENT GRADE:_____

PRIMARY GUARDIAN NAME:_____

PRIMARY GUARDIAN PHONE NUMBER:

_____

MEDICAL INSURANCE INFORMATION

STUDENT'S HEALTH INSURANCE
COMPANY:_____

POLICY/MEMBER ID NUMBER:_____

GROUP NAME OR
NUMBER:_____

EXPIRATION DATE:_____

MEDICAL INFORMATION

IN THE EVENT OF AN EMERGENCY, YOUR STUDENT'S WELFARE DEPENDS ON THE EXPLANATION OF ANY MEDICAL CONDITIONS. PLEASE BE SPECIFIC AND EXPLAIN YOUR ANSWERS BELOW:

HEART CONDITION:Y/N	STOMACH DISORDERS: Y/N
CONVULSIONS/SEIZURES: Y/N	SEASONAL ALLERGIES: Y/N
FOOD ALLERGIES:Y/N	ACTIVITY RESTRICTIONS: Y/N
MEDICAL ALLERGIES: Y/N	INSECT STING ALLERGIES:Y/N
DIABETES: Y/N	ASTHMA INHALER: Y/N

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE INDICATE HERE THE REASONS WHY IN DETAIL BELOW:

_____
_____
_____
_____
_____
_____

PLEASE LIST ALL MEDICATION PRESENTLY TAKING:

_____
_____
_____
_____
_____
_____
_____

MEDICAL PERMISSION AGREEMENT

I give permission for a designated chaperone to dispense the following over-the-counter drugs to my child for MINOR problems. These medications will be administered only at your child's request. Individual drug administration instructions will be followed, and if this does not take care of your child's problem, further medical attention will be provided. The following is permission for the following medications.

GUARDIAN'S NAME (PRINT):_____
DATE:_____

GUARDIAN'S NAME (SIGN):_____
DATE:_____

PAIN MEDICATION (PLEASE CIRCLE)

ADVIL	YES	NO
TYLENOL	YES	NO
ASPIRIN	YES	NO
ALEVE	YES	NO

UPSET STOMACH (PLEASE CIRCLE)

PEPTO	YES	NO
EMETROL	YES	NO

ALLERGIES/COLDS/INSECT BITES/MOTION SICKNESS (PLEASE CIRCLE ONE)

BENADRYL	YES	NO
CLARITIN	YES	NO
ZYRTEC	YES	NO
DRAMAMINE	YES	NO