Grade _________

Health History/Emergency Authorization Record

Please Fill Out A Form For Each Band Student Attending

Student name ____ **Birthday** ________________

Mother/Guardian__________________________________Home#________________Work#_____________Cell#______________

Father/Guardian__________________________________Home#________________Work#_____________Cell#_______________

Additional contact

Name____________________________Relationship_____________________Home#____________________Cell#_______________

Family Pediatrician_______________Phone #______________Dentist ____________________Phone#___________

Consent for Treatment: I give my permission for qualified personnel or parent chaperone to provide routine health care and first aid to my child/children as may be necessary. I assume full responsibility for providing the student with all necessary over-the-counter or prescription medications as well as necessary medical treatment supplies and authorizations. I give my permission for Mr. Johnson or associates to contact the physician(s) listed above and follow his/her instructions in the event I cannot be reached. As a parent/legal guardian I will remain fully responsible for any legal responsibility, which result from any personal actions taken by my child/children.

Parent/Guardian Signature____Date_______________________

Insurance Co. ____ Group or I.D. No. ____________________________

Medical Conditions (Check if apply)

ADD/ADHD	Headaches/Migraines	Nutritional Concerns
Allergies	Hearing Problem	Psychological /Emotional Concern
Asthma	Heart Defect or Disease	Psychiatric Illness
Convulsions/Epilepsy/Seizure	Immune System Disorder	Skin Condition
Digestive/Bowel Problem	Menstrual Problem	Soiling/Incontinence
Dizziness/Fainting	Mobility Limitations	Speech Disorder
		Vision/Eye Disorder
Diabetes Low blood sugar	Neurological Disorder	

ALLERGIES_______________________ Signs/symptoms of allergic reaction__________________ Medication given______________

***Provide details for all items checked above. List any other health care concerns.**

***Does the student take any medications, homeopathic supplements or nutritional & performance supplements? List.**

List medications that student may take. Please state if it is a daily medication. (May use back)

Medication **Dose** **Time to be taken**