YVONNE A. EWELL TOWNVIEW CENTER
DEPARTMENT OF FINE ARTS/BAND

MEDICAL HISTORY FORM FOR TREATMENT OF MINORS

Last Name_____First Name_____ MI____ ID#_____

Date of Birth_____School_____ Sex ☐M or ☐F Grade_

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____

Relationship _____

His/Her Address_____**Phone (____) _____**

Email_____ **Cell # (____)**_____

ALLERGIES TO MEDICATION OR OTHER SUBSTANCES? Yes☐ No ☐

Penicillin☐ **Sulfa**☐ **Aspirin**☐ **Insect Stings** ☐

Other _____

Reaction _____

Other medication taken on a regular basis:

_____

MEDICAL HISTORY: Please check if your child has or has had, any of the diseases or conditions listed below:

☐ Frequent Headaches	☐ Rubella	☐ Cancer	☐ Urinary Tract Infection
☐ Seizures	☐ Measles	☐ Anemia	☐ Asthma
☐ Eye Problems	☐ Mumps	☐ Hepatitis	☐ High Blood Pressure
☐ Ear Problems	☐ Polio	☐ Arthritis	☐ Hives
☐ Thyroid Problems	☐ Chicken Pox	☐ Diabetes	☐ Heart Problems
☐ Malaria	☐ Ulcer	☐ Depression	☐ Alcohol Problems
☐ Frequent cough, cold or sore throat	☐ Tuberculosis	☐ Drug Problems	☐ Pneumonia
	☐ Other (specify)		

Permanent Disabilities

(describe/date)_____

_____

Serious Illness/Injuries or operations

(describe/date)_____

_____

OVER

YVONNE A. EWELL TOWNVIEW CENTER
DEPARTMENT OF FINE ARTS/BAND

AUTHORIZATION FOR MEDICAL PROCEDURES: Permission is hereby granted to the Townview Band Administer recommended immunization upon request or to carry out indicated medical or surgical test or treatment. Permission is also granted to the Townview Band and/or the Band Director or staff to refer to another licensed physician for necessary emergency treatment.

Date_____Signature of Parent or Guardian _____

PARENTAL CONSENT FOR TREATMENT OF MINORS

I, THE Undersign, as the parent or legal guardian of a minor child, hereby authorize the physicians and their associates to perform such diagnostic, medical and/or surgical treatment on my child as may be deemed medically necessary in Order to assure the safety of my child. I understand that my child will be transported to a local hospital if the Band Director or Staff determine it is unable to fully/properly treat the injury. I also understand that I, the undersigned, are fully responsible for payment of all services related to the treatment of my child's injuries.

Date_____Signature of Parent or Guardian _____

PARENTAL CONSENT FOR RELEASE OF MEDICAL HISTORY TO LICENSED MEDICAL STAFF AND FACILITIES

I, THE Undersign, as the parent or legal guardian of a minor child, hereby authorize the Band Director or Staff to release medical information that is provided on this form to licensed emergency personnel, physicians and their associates to aid with the treatment of my child as may be deemed medically necessary in Order to assure the safety of my child.

Date_____Signature of Parent or Guardian _____

NAME OF INS. CO._____

POLICY#_____GROUP#_____

DOCTORS NAME_____PHONE(___)_____

Please submit a copy of your child's insurance card.

If you Do Not have insurance, please check this box. ☐