

Pickens High School 2020-2021 Medical Form

STUDENT NAME: _____ STUDENT ID #: (five digit) _____

STUDENT CELL: _____ PARENT CELL: (M) _____ (D) _____

HOME PHONE: _____ DATE OF BIRTH: _____

In the event of an emergency while my student is involved in a school band trip, I grant permission to the school, Mr. Oubre, or the chaperones to take whatever action necessary to obtain emergency care or treatment if deemed necessary. In the event that I cannot be reached, I hereby authorize the above named to give consent for my son/daughter to receive medical treatment.

Student Address _____

Student Date of Birth _____ S.S. # _____

Mother's Name _____ Mother's Work # _____

Father's Name _____ Father's Work # _____

Student E-mail Address (write clearly!) _____

Parent E-mail Address (write clearly!) Mother _____

Father _____

Health Insurance Company _____

Insured's Name _____

Policy/Member ID Number _____ Group Name or Number _____

THIS IS VITAL INFORMATION IN CASE OF EMERGENCY- PLEASE FILL IT OUT!

Person(s) to be notified other than parent or guardian in an emergency:

Name/Phone _____ Name/Phone _____

MEDICAL INFORMATION

In the event of an emergency, your child's welfare depends on explanation of any medical problems. Please be specific. **Circle yes or no.** Explain yes answers below.

Heart condition or disease	YES	NO	Diabetes	YES	NO	Insulin? _____
Convulsions/Seizures	YES	NO	Bone/Joint problems	YES	NO	
Nervous Conditions	YES	NO	Food/environmental			
Physician-requested			allergies/intolerance	YES	NO	
activity restrictions	YES	NO	Seasonal allergies	YES	NO	
Headaches/migraines	YES	NO	Stomach disorders	YES	NO	
Fainting spells	YES	NO	Cold/Heat intolerance	YES	NO	
Sleep disorders	YES	NO				

A. Has your child, or anyone in your immediate family, had a life-threatening reaction to an insect sting?

YES NO

Please give date and brief description _____

B. Does your child have asthma requiring oral medications or inhalers? **YES NO**

C. Has your child ever had a life threatening allergic reaction to over the counter or prescription medications?

YES NO

NOTE If you answered YES to questions A. B. or C., you MUST SPEAK DIRECTLY with the chaperone chairperson before band camp (before pre-band camp for upcoming freshmen) to insure that the proper emergency kits and/or treatment is available.

Student's primary care physician _____

Hospital preference* _____

(*If applicable & if possible. Life threatening illnesses/injuries will be treated at the nearest emergency center)

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Additional information that may be helpful: _____

LIST ALL MAINTENANCE MEDICATIONS PRESENTLY TAKING, GIVING GENERAL INSTRUCTIONS AND MEDICAL CONDITION BEING TREATED

For overnight trips, you must provide the chaperone chairperson with a signed note detailing the name of medication not listed above, dosage, and any storage requirements. The chairperson will be available to store the medication, and dispense to your student, at your request. (Note: any narcotic-containing medication must be stored in the medical bag and dispensed by the chairperson or other designated adult.)

While away on trips, I give permission for a designated chaperone to dispense to my child any of the below over-the-counter drugs 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. Please initial yes or no, indicating your permission to administer the following medications. If you have any questions, please talk with your doctor or pharmacist before initialing.

LIST ANY KNOWN ALLERGIES TO MEDICATIONS: _____

PAIN MEDICATIONS FOR HEADACHE, GENERAL DISCOMFORT, FEVER, MENSTRUAL CRAMPS:

YES	NO	YES	NO
HEADACHE:		COLDS, RUNNY NOSES:	
Advil tablets	_____	Benadryl	_____
Tylenol tabs	_____		
INDIGESTION:		UPSET STOMACH:	
TUMS	_____	Pepto Bismal	_____
NAUSEA/VOMITING:		INSECT BITES:	
Meclizine	_____	Benadryl	_____

IF YOUR CHILD HAS MOTION/CAR SICKNESS, PLEASE ADVISE US OF THIS, AND PROVIDE US WITH YOUR DRUG OF CHOICE.

PLEASE REMEMBER THAT YOUR STUDENT WILL BE TRAVELING OFTEN TO BAND FUNCTIONS. THIS MEDICAL FORM WILL BE TAKEN TO ALL AWAY FUNCTIONS, AND IS OUR LINK TO PROVIDING SAFE AND EFFECTIVE CARE FOR YOUR CHILD. ANY CHANGES IN MEDICAL HISTORY OR NEW MEDICAL PROBLEMS MUST BE REPORTED TO BAND PERSONNEL. THANK YOU!

Please call with any questions or concerns not listed on this form, or to provide additional medical information that you want documented regarding your student. Thank you!

Student Signature

Parent/Guardian Signature

Student Shirt Size

Date _____

Date _____
