Student Information and Health Form 2019-2020

Please provide all updated contact information for your band student and his/her parents. Medical information is kept confidential and used by the band nurses to provide medical and emergency care for your child.

Last Name:_____ First Name: _____

Preferred Name:_____ Date of Birth: _____

Section:_____ Graduation Year: _____

LHS Student number [NOT SSN]: 6 9 2 ___ ___ ___ ___ ___ Home Phone: _____ Student Cell: _____

Home Address:_____

(STREET) (CITY) (STATE) (ZIP)

Family home email: _____

Mother's Name: _____ Phone #1_____ Phone #2 _____

☐ Same as Address: above: _____

(STREET) (CITY) (STATE) (ZIP)

Employer:_____ Work telephone: _____

Work email: _____

Father's Name: _____ Phone #1_____ Phone #2 _____

☐ Same as Address: above: _____

(STREET) (CITY) (STATE) (ZIP)

Employer:_____ Work telephone: _____

Work email: _____

In case of Emergency and I cannot be contacted, please contact:

Name:_____ Relationship: _____

Phone #1:_____ Phone #2: _____

Name:_____ Relationship: _____

Phone #1:_____ Phone #2: _____

HEALTH HISTORY

Student's Name: _____

Any Allergies?: **Y** **N** Please list: ____

Date of Last Tetanus: _____ Date of Last Physical: _____

Has your child ever been diagnosed with any of the following?

Diabetes: Y N Heart Murmur: Y N Heart Problems: Y N

Seizures: Y N Asthma: Y N High Blood Pressure: Y N

Sickle Cell Anemia: Y N Depression: Y N ADHD: Y N

Migraines: Y N Other: _____

Past surgical history: Y N _____

Please list any medications taken by your child: 1. _____ 2. _____ 3. _____ 4. _____

Does your child have any condition that will interfere with physical activity? Y N

Explain: _____

Doctor's name: _____ Phone #: _____

Insurance: _____ Policy Holder: _____

Group #: _____ Policy #: _____

In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be contacted, I hereby give my permission to the Physician selected by the Band Director or Band Nurse in charge to secure proper treatment, which may include hospitalization, anesthesia, surgery, or injections of medication to my son/daughter. I understand this may also include transportation to a Medical Facility or home. I understand that I will be responsible for any charges incurred in the treatment of my son/daughter under such circumstances.

Parent/Guardian signature: _____ Date: _____

I give permission for my child to be given by the Band Nurse, if needed, over-the-counter medications (ex., Tylenol, Pepto-Bismol, cold medications) and first aid for cuts, scratches, bruises, etc. I also accept full responsibility for any medications my son/daughter may take without the knowledge of the Band Nurse and relieve the school, Band Directors, and Band Nurse of any legal responsibility.

Parent/Guardian signature: _____ Date: _____