

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

**Health Form**  
**2023-2024 Soddy Daisy High School Band**

**Health History**

Please check all that apply and explain below. If there is a treatment, please give detailed description.

Drug Allergy (list) \_\_\_\_\_ Asthma \_\_\_\_\_  
Food Allergy (list) \_\_\_\_\_ Heart Problems \_\_\_\_\_  
Insect Bite Allergy (life threatening) \_\_\_\_\_ Musculoskeletal Problems \_\_\_\_\_  
Serious Injury/Surgery \_\_\_\_\_ ADHD \_\_\_\_\_  
Seizure Disorder (type) \_\_\_\_\_ Other \_\_\_\_\_

Current Medications \_\_\_\_\_

Details and/or Treatment Information: \_\_\_\_\_

Physical Activities to be restricted-include reason & details: \_\_\_\_\_

Date of last Tetanus Shot: \_\_\_\_\_

Student's Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Office Address: \_\_\_\_\_

Number                      Street                      City                      State/Zip

**Medication/Parental Permissions**

Permission for Provided Over-the Counter Medications Provided by the Band Boosters

I give my permission for the nurse employed by the school system or other authorized school personnel to assist my child with the self-administration of each of the following medications that I have initialed:

Parent/Guardian Signature \_\_\_\_\_

Tylenol	Ibuprofen	Benadryl
Sudafed	Tums	Mylanta
Calamine Lotion/Band-Aid	Artificial Tears of Bausch & Lomb Eye Wash	Cough Drops
Cepacol Spray	Anbesol Ointment/Orajel	Mineral Ice
Antibacterial Ointment	Vaseline	Aloe Vera or Aloe Gel
Destin	Baby Oil	Liquid Band-Aid

**Permission of Prescription and All Other Over-the-Counter Medications**

Any over-the-counter medication not on the previously mentioned list must have physician order and be in their original, unopened container with original label listing the ingredients. The student's name must be written on the container.

All prescription medications must be in the original pharmacy-labeled container and must have physician order.

I give my permission for the nurse employed by the school system or other authorized school personnel to assist with the self-administration of prescription and all other over-the-counter medications to my child.

Parent/Guardian Signature \_\_\_\_\_

**Permission for Accompanying Physician**

I give my permission for any physician who is accompanying the band on a trip to provide medical treatment to my child if needed.

Parent/Guardian Signature \_\_\_\_\_

**Permission for Emergency Medical Treatment**

In the event of an emergency and I am (or other emergency contact is) unable to be reached, I give permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic.

Parent/Guardian Signature \_\_\_\_\_

Health Form  
2023-2024 Soddy Daisy High School Band

Student's Full  
Name: \_\_\_\_\_

Parent or  
Guardian: \_\_\_\_\_

Printed Name

Signature

Date

Parent of  
Guardian: \_\_\_\_\_

Printed Name

Signature

Date

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**TENNESSEE NOTARY ACKNOWLEDGEMENT**

State of Tennessee

County of Hamilton

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ [Day/Month/Year], before me personally appeared \_\_\_\_\_, to me known to be the person described in and who executed the foregoing instrument, and acknowledged that such person executed the same as such person free act and deed.

Witness my hand, at office, this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary's Signature

My commission expires: \_\_\_\_\_

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\_\_\_\_\_  
Notary's Signature

My commission expires: \_\_\_\_\_