

Health Form  
2018-2019 Soddy Daisy High School Band

**Mail to:** Soddy Daisy HS Band  
618 Sequoyah Rd.  
Soddy Daisy, TN 37379  
Grade \_\_\_\_\_  
Instrument \_\_\_\_\_

**A completed health form with parent's signature and a copy of current insurance card must be on file when Band Camp begins. All items must be completed by a parent or guardian.**

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle mo/day/year

Student's Address \_\_\_\_\_  
Number Street City State/Zip

Father's Name \_\_\_\_\_

Father's Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Father's Address \_\_\_\_\_  
Number Street City State/Zip

Mother's Name \_\_\_\_\_

Mother's Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Mother's Address \_\_\_\_\_  
Number Street City State/Zip

Family e-mail address: \_\_\_\_\_

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**A COPY OF YOUR INSURANCE CARD EXPEDITES TREATMENT IN THE EMERGENCY ROOM. PLEASE ATTACH A COPY OF INSURANCE CARD TO THIS FORM.**

No medical insurance at this time \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_  
Number Street City State/Zip

Group # \_\_\_\_\_ ID# or subscriber # \_\_\_\_\_

Type of Insurance: Private \_\_\_\_\_ Group \_\_\_\_\_

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**IN CASE OF EMERGENCY AND YOU CANNOT BE REACHED**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
Number Street City State/Zip

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

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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 \_\_\_\_\_

**NOTARY PUBLIC:** \_\_\_\_\_

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