Health Form
2018-2019 Volunteer High School Band

Mail to: VHS Band Boosters
P.O. Box 952
Church Hill, TN 37642

Grade_____

Instrument_____

A completed health form with parent's signature and a copy of current insurance card must be on file before July 4th, 2017. All items must be completed by a parent or guardian.

Student's Name_____ Date of Birth _____
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: _____

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) _____

Health Form Page 2 – 2018-2019

Student's Name: _____

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

Medication

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 _____