2009-2010 SOMERSET HIGH SCHOOL "BLUE RAIDER" MARCHING BAND HEALTH FORM

Student Name: ____ Section/Squad: _____________________ Grade: ____

Parent/Guardian Name: ____

Address: ____ City: ____________ State ____ Zip: ______

Home Telephone: _________________________________ Business/Day Phone: _______________________________

1. If a parent is not available in the unlikely case of an emergency, please notify: (Give two names other than parents)

   Name: ____ Name: ____

   Relationship: ____________________________________ Relationship: ____________________________________

   Phone: ____ Phone: ____

2. Physician's Name: ____ Phone: ___________________________

3. Does your son/daughter have any **illness** that (s)he is being treated for? (Ex. Diabetes, epilepsy, asthma) Yes _____ No _____
   If yes, Indicate illness: _______________________________
   (All information given is confidential.)

   If asthmatic, does you son/daughter use an inhaler?
   Yes _____ No _____ If yes, name of inhaler: ____
   Please be sure your son/daughter has an extra inhaler. Please instruct your son/daughter to keep the inhaler with him/her at all times. The school nurse should be given the extra inhaler in case of loss.

4. Please list any **medications** your son/daughter takes on a regular basis. **(Please be sure to send it with them.)**
   Indicate below the name of the medication and the specific times of day to be taken:

   Medicine: _____________________________________ Time to be taken: ______________________________

   Medicine: _____________________________________ Time to be taken: ______________________________

   Medicine: _____________________________________ Time to be taken: ______________________________

5. Please indicate if your son/daughter is **allergic** to the following. (Yes or No)

   Ibuprofen (Advil) _____ Penicillin _____ Aspirin _____ Other Drugs ____

   Bee stings _____ Food Allergy ____

   If yes, please describe the type of **reaction**, (Hives, breathing difficulties, swelling, etc.)
   ____

Important: Persons allergic to bee stings must have a bee sting kit with them at all times. (Available by calling physician.)

6. If it is felt that your son/daughter should have the **medication** listed here, may an official chaperone administer your son/daughter the medicine? (Yes or No)
   Cough syrup ______ Cold/allergy pill ______ Tylenol ______ Advil ______ Something for upset stomach ______
   Dramamine ______ Other (Please indicate preference) ____

7. Date of last **tetanus** shot: ___________________________________

8. Please indicate health insurance information:
   Plan: ____
   If Blue Cross/Blue Shield, indicate MA or RI ______________
   ID Number: ____
   Subscriber's name: _____________________________________ ***(Attach a copy of card if possible)***

9. Suggestions from parents as to limitations or signs of health risks for chaperones to be aware of:
   ____
   ____

10. Has your son/daughter been recently exposed to any contagious disease? Yes _____ No _____
    If yes, what disease? ____

Authorization: This Health History is correct insofar as I know and the student therein described has my permission, as legal parent/guardian, to engage in all prescribed tour activities, except as noted by me in the space provided above. In the event that I or the individuals listed above for emergency notification cannot be reached in an "emergency", I hereby give my permission to the physician selected by Mr. David M. Marshall to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my son/daughter as named above.

Parent/Guardian Signature: ____ Date: _____________

RETURN THIS FORM TO MR. MARSHALL BY JUNE 29, 2009