

2011-2012 SOMERSET-BERKLEY RHS "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 your 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 28, 2011