

# 2011-2012 SOMERSET BERKLEY REGIONAL HIGH SCHOOL MUSIC DEPT. 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 DECEMBER 7, 2012**