# LITHONIA HIGH SCHOOL MARCHING BAND 2016-2017

## MEDICAL HISTORY FORM

**Student Name:** ______________________________________________
Last First Middle

**Date of Birth** ______________________ ☐ **Male** ☐ **Female**

**GRADE**_________ **INSTRUMENT**____________________________________

**PARENT/GUARDIAN NAME:** ____________________________________

**CONTACT PHONE NUMBERS:**

| | Cell | Home | Work |
|---|---|---|---|
| **Mother** | | | |
| **Father** | | | |
| **Student** | | | |
| **Emerg Contact Name:** | | | |
| **Relationship:** | | | |

**Please check any medical issues your child has currently, or has had in the past:**

**Heart:**
- ☐ No known problems
- ☐ Hypertension
- ☐ Angina
- ☐ Heart attack
- ☐ Tachycardia/Bradycardia

**Lungs:**
- ☐ No known problems
- ☐ Asthma
  Type of inhaler used___________________________
- ☐ Chronic lung disease________________________
- ☐ Have Tuberculosis
- ☐ Exposed to Tuberculosis

**Head:**
- ☐ No known problems
- ☐ Seizures
- ☐ Severe Headaches/Migraines or Recurring headaches

**Disorders:**
- ☐ No known problems
- ☐ Stroke
- ☐ Dizziness or Fainting Spells

**Endocrine:**
- ☐ No known problems
- ☐ Diabetes Type 1 or 2/Insulin dependent
- ☐ Thyroid (hyper-hypo)

**Urinary Tract:**
- ☐ No known problems
- ☐ Frequent urination
- ☐ Renal disease ____________________________
- ☐ Hemodialysis

**Bones, Joints and Muscles:**
- ☐ No known problems
- ☐ Broken bones
- ☐ Joints or Muscle pains
- ☐ Back/Neck problems

**Blood Disorders:**
- ☐ No known problems
- ☐ Anemia/Sickle Cell
- ☐ Aplastic Anemia
- ☐ G-6pd Deficiency
- ☐ Hemophilia/Other ______________________

**Allergies:**
- ☐ Medications______________________________
- ☐ Food___________________________________
- ☐ Bee stings, insect bites

**Digestive:**
- ☐ No known problems
- ☐ Nausea/Vomiting Syndrome
- ☐ Ulcers
- ☐ Severe stomach cramps
- ☐ Irritable Bowel Syndrome

**Is child ____ or on a specific diet? If so please list____________________________________________________________**

**Please list any medications your child is taking and the dosage:**

| Medication | Dosage | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

The certified nurse, and/or Band Directors have my permission to administer the above listed medications to my child.

☐ YES ☐ NO

The nurse has my permission to administer the following pain medication to my child, if deemed necessary.

☐ Aspirin ☐ Tylenol ☐ Motrin

The nurse has permission to escort my child to the hospital in case of emergency.

☐ YES ☐ NO

Preferred Hospital _____________________________________________________________

Child's Physician __________________________________ Phone #__________________________

**Insurance Information**

Company Name ___________________________ Phone # _________________________

Primary Policy Holder____________________________________________________________

Policy # __________________________ Group # ___________________________

**Please sign below to acknowledge consent of all of the above.**

**Parent/Guardian Signature** _____________________________________ Date ____________

**Nurse Signature** _________________________________________________ Date ____________

**Revised: July 9, 2015**