

EMERGENCY INFORMATION

STUDENT INFORMATION:

Last Name _____ First _____ Middle Initial _____
 Address: _____ City/Zip _____
 DOB _____ Grade _____ Home Phone: _____

PARENT/GUARDIAN INFORMATION:

Female Guardian Name: _____ Relationship _____
 Work Phone: _____ Cell Phone: _____ Email: _____

Male Guardian Nam: _____ Relationship _____
 Work Phone: _____ Cell Phone: _____ Email: _____

INSURANCE INFORMATION:

Company Name: _____ Policy No. _____
 Doctor: _____ Hospital Preference: _____

MEDICAL INFORMATION

LIST ALL CURRENT MEDICATIONS AND REASON FOR EACH, INCLUDING OVER THE COUNTER MEDICATIONS.

Medication Name	Reason

FOOD ALLERGIES:

Allergic to Insects: YES NO Bees: YES NO EPI Pen? YES NO

MEDICAL CONDITION	Current	Past	None	MEDICAL CONDITION	Current	Past	None	MEDICAL CONDITION	Current	Past	None
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Allergies to Medications: (write N/A if not applicable): _____

Has Your Child had a tetanus shot within the last 6 years? Yes No

List all other conditions or factors your child is known to have:

(over)

PERMISSION FORM

_____ has my permission to participate in all band activities. I

Understand that most of these activities take place in Escambia County. However; I also understand that Some activities may take place outside the county and some may take place outside the State of Florida.

The Health History I have provided is accurate to the best of my knowledge.

SIGNATURE OF LEGAL GUARDIAN

DATE

SIGNATURE OF LEGAL GUARDIAN

DATE

THIS FORM MUST BE NOTARIZED BY A NOTARY PUBLIC

Sworn and subscribed before me _____, a
Notary Public in the State of Florida, County of Escambia, this ____ day of _____
in the year _____.

_____ is personally known to me and/or provided
Identification in the form of _____.

_____ Notary Public State of Florida

(Seal)