



2014 Uintah High School Marching Band Student Medical & Health Form

IMPORTANT! PLEASE READ: This form must be submitted before May 16th. This Medical / Health form will be kept with the medical kit at all times in case of a medical emergency involving your student. Make sure ALL blanks are completed. If an item does not apply to your student, please put NA in the blank to insure accurate information. **Incomplete forms can not be accepted.**

Student's Full Name: _____ Date of Birth: _____

Gender: M F Grade (Fall 2014): 9 10 11 12 Instrument / Position: _____

Primary Emergency Contact* _____ Phone: _____

Secondary Emergency Contact* _____ Phone: _____

**The Primary and/or Secondary contact should be easily contacted. Please list the phone number most likely to be answered.*

Health History

Operations (Within the last Year) _____

Individual Health Concerns (Hyperventilation, fainting, seizures, etc.) _____

Last Tetanus Shot? _____ Student's Blood Type? _____

Does the student have, or ever have had, any of the following?
Rheumatic Fever: _____ Diabetes: _____ Epilepsy: _____ Asthma: _____ Seizures: _____ Allergic reactions to stings: _____
If your student uses a Glucagon injection kit or an Epi Pen, please provide one to be kept in the medical kit throughout the season

Medication Allergies? _____

List all medications that the student takes on a daily basis: _____

List any medical procedures that you would not want performed: (Blood transfusions, etc.) _____

Student's Physician _____ Phone Number _____

Student is covered under the following insurance policy:

Insurance Policy in the name of: _____ Group Number: _____

Insurance Company: _____ Policy Number: _____

Limited Power of Attorney

In the event that a serious emergency arises, it may be necessary for a physician to attend to your student before the staff can reach you or your designated physician. Such emergency care can be provided only if you sign the following **Authorization to Provide Medical Treatment**. (All information below is required for emergency treatment of your student).

AUTHORIZATION TO PROVIDE MEDICAL TREATMENT

I hereby give the band director or chaperone in charge of my son / daughter limited power of attorney to act in my absence and see that _____ **(student's name)** receives whatever medical treatment is necessary in the event of an emergency.

Parent / Legal Guardian Signature: _____

Parent / Legal Guardian Name Printed: _____

Do you grant band personnel / chaperones to administer over the counter medications? (Pain Meds / Allergy Meds / etc.) Y N

This form needs to be completed and handed in to Mr. Gibson before May 16. No Exceptions!