

HEALTH HISTORY FORM

(This information is confidential and will be used only in case of emergency.)

Name of Band Member: _____

Social Security Number: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Is your child subject to:	Yes	No	Does your child have or has ever had:	Yes	No
Colds	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Lung trouble	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to fish / sea food	<input type="checkbox"/>	<input type="checkbox"/>	Has appendix been removed ?	<input type="checkbox"/>	<input type="checkbox"/>

Last monthly period: _____

Date of Child's last Tetanus Vaccination: _____

Please identify child's allergies, including allergies to food, medications, or drug reactions you know about:

Please list any disabilities or disorders that may affect your child's participation at this Band function, such as orthopedic (bone or muscle injuries) or medical condition(s):

Is the child currently under any type of medical treatment? ___ NO ___ YES, explain:

Name of Band Member: _____

If your child is bringing prescription medication(s) on this trip, please complete and sign this section. EACH MEDICATION MUST BE IN ITS ORIGINAL CONTAINER. THE NUMBER OF PILLS / AMOUNT IN THE CONTAINER MUST BE CLEARLY MARKED ON THE CONTAINER AND LISTED ON THIS SHEET.

Please list all medications that child is presently taking AND BRINGING:

Name of Medication	Amount In Container	Dosage	Times Taken	Reason for Taking

The above information and directions for administration of medications is complete and correct.

I / We understand that the Band Director, or designee, may ask to check the medication(s) or verify that my / our child has taken them as prescribed.

I / We have informed my / our child NOT to give, share, or other wise distribute their medication(s) with anyone.

_____ I / We authorize my / our child to carry and self administer the above listed medications.

_____ I / We authorize the Band Director, or designee, to carry and administer the above listed medications.

Please identify over-the-counter medications that may be administered by Band Director or Designee.

- Tylenol (acetaminophen)
- Advil (Ibuprofen)
- Sudafed (pseudoephedrine)
- Dramine (or equivalent)
- DayQuil (or equivalent day time cold / flu medication)
- NiteQuil (or equivalent night time cold / flu medication)
- Robitussin cough syrup
- Throat Lozenges
- Maalox / Mylanta
- Benadryl (diphenhydramine)

Signature of Parent / Legal Guardian: _____ Date: _____

Name of Band Member: _____

Other medications / treatments that child may be given:

Remarks and any special instructions.

Continuation of Medications:

Name of Medication	Amount In Container	Dosage	Times Taken	Reason for Taking

Signature of Parent / Legal Guardian: _____ Date: _____

Student Information Sheet

(This information is confidential and will be used only in case of emergency.)

Student's Full Legal Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Social Security Number: _____

Medical Insurer/Health Plan: _____

PLEASE PROVIDE COPY OF CARD

Policy #: _____ ID #: _____

Name of Carrier: _____

Name of person policy is under / issued: _____

Parent / Legal Guardian #1:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____

Parent / Legal Guardian #2:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____

Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____