Cienega High School Instrumental Program Medical Form

School Year: _____-_____

Name: (Last, First, Middle)		Grade:
DOB:	Age:	Sex:
Address:		

Emergency Contacts		
Name:		
Relationship:		
Cell Phone:		
Home Phone:		
Work Phone:		

Physician/Insurance	
Physician:	Telephone:
Physician Address:	
Insurance Carrier:	Telephone:
Policy ID:	Group:

Medical History		
☐ Allergies (not seasonal)	☐ Asthma	☐ Bleeding Disorders
☐ Diabetes	☐ Heart Disease	☐ Seizures
☐ Other:		Last Tetanus:
Allergies:		
Medications:		
Activity Limiting Restrictions:		

The CHS Band Booster Club maintains a first aid/medical kit. Over the counter medications may be administered by a chaperone when necessary, but only with parent/guardian permission.

I give permission to an adult in charge of First Aid to administer the following to my child as needed:

☐ Advil (Ibuprofen)	☐ Decongestant	☐ Saline Eye Wash
☐ Tylenol (Acetaminophen)	☐ Triple Antibiotic Ointment	☐ Antacids
☐ Benadryl (Diphenhydramine)	☐ Hydrocortisone Cream (1%)	

I give permission for the above-named student to receive the following prescription medication:
Prescription drugs must be labeled and in the original container.

Medication:	Dosage:	Time: AM PM
Medication:	Dosage:	Time: AM PM

I request that the medication:
- ☐ Be administered by a Band Chaperone
- ☐ Be carried by the Student for self-administration

This information will remain in effect for one year from the date below, unless notified in writing. To my knowledge, all the above information is correct. I understand that in the event of an emergency, every effort will be made to contact the parent/guardian. If unable to be reached, I give permission to have the physician/person selected by the Director/CHS Band Booster Club secure proper treatment. I also understand that Cienega High School, CHS Band Booster Club, and Chaperones are not liable or responsible for injury/accidents that may occur during band events. There are also restrictions to the uses of private health information of my student.

Parent/Guardian Signature: _____ Date: _____