

**2009-2010
MEDICAL INFORMATION**

School Name: **North Augusta High School** County: **Aiken County Public Schools**

Student Name: _____ Age: _____

Address: _____ D.O.B.: _____

Student Social Security #: _____ Home Phone: _____

Name of Parent/Guardian: _____

Business Address/Phone Number: _____

Does student have insurance through parent employer? Yes _____ No _____

Policy Number: _____ and copy of insurance card must be attached to medical form.

Health History: (check) Allergies: (check)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Cardiac Problems	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Other (specify) _____

The NAHS Band will have the following OTC medications in the band medical kit. Please indicate which of the following medications you wish for your child to receive while participating/traveling with the band, if needed.

<input type="checkbox"/> Motrin	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Mylanta	<input type="checkbox"/> Tums
<input type="checkbox"/> Benadryl	<input type="checkbox"/> Imodium	<input type="checkbox"/> Sudafed	

In addition, if you are sending any medication from home to be administered to your child while participating/traveling with the band, you must complete and send a Jacket Regiment **Permission for Medication Form**. (*This must be done every time you send medication to be administered.*)

Has your child had a tetanus shot current to within six years? Yes _____ No _____

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? If yes, please explain.

Special Considerations (Optional):

MEDICAL RELEASE

I give permission to the physician and/or hospital to secure proper treatment for and to order medications, injections, anesthesia and or surgery for my child as named above.

Signature of Parent/Guardian _____ Date Signed _____

Printed Name of Parent/Guardian _____ Relationship: _____