

HEALTH HISTORY (To be completed by parent/guardian)

Student Name _____ Date of Birth _____ Male/Female _____

Circle any of the following conditions that your child may have or had in the past:

- | | | | |
|-----------------------|--------------------|--------------------|----------------------|
| Allergy (medications) | Diabetes | Menstrual Cramps | Tuberculosis |
| Anemia | Emotional Problems | Migraine Headaches | Valley Fever |
| Arthritis | Fractures | Seizures | Other |
| Asthma | Hearing Problems | Sinus Problems | Dietary Restrictions |
| Back Pain | Heart Murmur | Skin Rashes | Vegetarian |
| Blackouts | Hernia | Sore Throat | Food Allergies |
| Concussion | Kidney Problems | Surgery | |

If you circled any of the above, please give dates and details _____

Date of last tetanus shot _____ (Month/Year) **DO NOT LEAVE BLANK
*If more than ten years ago, student must have a current tetanus shot before the trip.***

Do you give permission to the first aid staff to dispense Tylenol/Advil to your child if requested and deemed appropriate? YES NO

Is your child taking any medicines (over-the-counter or prescription)? YES NO

If yes, what? _____ What for? _____

**List any over-the-counter or prescription medicines to be taken to camp/trip (must be updated before each trip if there are changes): _____

****All over-the-counter and prescription medicines – except Tylenol/Advil - must be in the original container and given to the first aid volunteer prior to departure.****

PARENTAL PERMISSION FOR ACTIVITY

The above named student is given my permission, as a legal guardian, to participate in all band activities which depart Desert Vista High School during the school year from June 15, 2011 – June 15, 2012.

EMERGENCY MEDICAL SERVICE: If emergency service involving medical action or treatment is required, I hereby consent for the student named above to be given medical treatment by the doctor or hospital selected by the director or chaperone. Every effort will be made by the staff in charge to contact the parent or guardian immediately. I hereby state responsibility for any medical expenses incurred for my student.

We have read, understand and agree to the information contained on this form.

Parent/Guardian Signature _____ Date _____

*****REQUIRED SIGNATURE BELOW*****

Subscribed and sworn to before me this _____ day of _____.

NOTARY PUBLIC/SCHOOL ADMINISTRATOR My commission expires: _____