PLEASE SIGN, COMPLETE AND RETURN THE FOLLOWING INFORMATION

Centennial High School Band Student
Confidential Information Sheet and Medical Release Form

Student Name:_____ DOB: _____

Home Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Mother/Parent/Legal Guardian Full Name: _____

Home Number: _____ Work Phone: _____ Cell Phone: _____

Email: _____@_____._____

Father/Parent/Legal Guardian Full Name: _____

Home Number: _____ Work Phone: _____ Cell Phone: _____

Email: _____@_____._____

All over-the-counter medications and prescribed medications must be self-administered by the student. They need to provide and carry their own medication(s) for this purpose.

List all medications the student is taking, if any: _____

_____

Does the student get motion sickness? _____Yes _____No

If yes, the parent must provide Dramamine or other medication and list the dosage to be taken by the student.

Name of medication: _____ Dosage: _____

List any allergies the student has, if any (i.e. food allergies, bee stings, peanut, etc.): _____

_____

List any dietary restrictions the student has, if any (i.e., religious, vegetarian, etc.): _____

_____

Does the student wear contact lenses? Yes _____ No _____

Does the student have dental braces? Yes _____ No _____

Does the student wear a retainer? Yes _____ No _____

List any restrictions to medication/injections the student has, if any: _____

_____

Please indicate if the student has had or is currently under treatment for the following conditions:

_____ Asthma
_____ Diabetes
_____ Ear/Hearing Problems
_____ Emotional Problems
_____ Seizures
_____ Muscular Weakness
_____ High Blood Pressure
_____ Migraine Headaches
_____ Heart Problems – Type: _____
_____ Hepatitis – Type: _____
_____ Meningitis – Type: _____
_____ Bleeding Disorders – Type: _____
_____ Infections Disease – Type: _____
_____ Other – Type: _____

Have you ever been informed of the need for the student to be on antibiotic therapy prior to dental treatment?

Yes _____ No _____ If yes, list required therapy: _____

Please attach a list of any problems not listed or any special measures that need to be taken with your student.

Medical Insurance Information:

Company Name: _____ Phone: _____

Policy Number: _____ Group Number: _____

Primary Insured Member's Name: _____

Employer: _____

In the event that I cannot be reached in an emergency, I hereby give permission to the directors/chaperones to secure proper transport and medical treatment for my child. All medical costs incurred during the trip are the responsibility of the student and/or family.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Additional Adult Contact:

Name: _____ Phone: _____

Relationship to Student: _____