 **2012-2013**

**MEDICAL INFORMATION**

School Name: **Wren High School** County: **Anderson County District One Public Schools**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_

Student Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Phone #’s: Father Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does student have insurance through parent employer? Yes\_\_\_\_\_ No\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health History: (check) Allergies: (check)

\_\_\_\_\_Diabetes \_\_\_\_\_Aspirin

\_\_\_\_\_Orthopedic Problems \_\_\_\_\_\_Penicillin

\_\_\_\_\_Asthma \_\_\_\_\_Sulfa

\_\_\_\_\_Epilepsy \_\_\_\_\_Insect Stings

\_\_\_\_\_Cardiac Problems \_\_\_\_\_Tetracycline

\_\_\_\_\_Latex Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***The WHS 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.***

\_\_\_\_\_Motrin \_\_\_\_\_Tylenol \_\_\_\_\_Mylanta \_\_\_\_\_Tums

\_\_\_\_\_Benadryl \_\_\_\_\_Imodium \_\_\_\_\_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 **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.

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Special Considerations (Optional):

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**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.

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Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_