

# STUDENT HEALTH HISTORY FOR ROLLING MEADOWS MUSIC DEPARTMENT

( Please print )

STUDENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

ADDRESS, CITY \_\_\_\_\_ BUSINESS PHONE # \_\_\_\_\_

EMERGENCY CONTACT (other than parent) \_\_\_\_\_ PHONE # \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ OFFICE PHONE # \_\_\_\_\_

HEALTH HISTORY: (please give dates where known) \*COMPLETE ON ADDITIONAL PAPER IF NEEDED\*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OPERATION (within last two (2) years) \_\_\_\_\_ RHEUMATIC FEVER \_\_\_\_\_

EMOTIONAL PROBLEMS (i.e., hyperventilation, hysteria) \_\_\_\_\_

SERIOUS MEDICAL PROBLEMS \_\_\_\_\_ MEDICATION TAKEN \_\_\_\_\_

DIABETES \_\_\_\_\_ NAME OF INSULIN TAKEN, AMOUNT AND TIME \_\_\_\_\_

EPILEPSY \_\_\_\_\_ MEDICATION TAKEN, AMOUNT AND TIME \_\_\_\_\_

TRANQUILIZERS \_\_\_\_\_ ALLERGY TO DRUGS (specify i.e. penicillin, insulin, sulfa, etc.) \_\_\_\_\_

ARE YOU PRESENTLY UNDER TREATMENT FOR ANY MEDICAL PROBLEM? \_\_\_\_\_

IF YES IDENTIFY: \_\_\_\_\_

ARE THERE ANY PHYSICAL CONDITIONS THAT MAY LIMIT ACTIVITIES? \_\_\_\_\_

IF YES PLEASE LIST: \_\_\_\_\_

PLEASE LIST ANY OTHER MEDICATIONS YOUR STUDENT IS TAKING ON AN ADDITIONAL SHEET OF PAPER.

CAN TAKE AND HAVE APPROVAL TO TAKE: ASPIRIN TYLENOL MOTION SICKNESS MEDICATION \_\_\_\_\_

DATE OF LAST TETANUS SHOT \_\_\_\_\_ SPECIAL DIETARY NEEDS? \_\_\_\_\_

PLEASE LIST: \_\_\_\_\_

MEDICAL RELEASE:

STUDENTS COVERED BY GROUP OR OTHER MEDICAL INSURANCE AS FOLLOWS:

NAME OF INSURED \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

GROUP # \_\_\_\_\_ POLICY # \_\_\_\_\_

**ROLLING MEADOWS HIGH SCHOOL MUSIC DEPARTMENT TRAVEL  
CONSENT/MEDICAL RELEASE FORM**

**TRAVEL CONSENT**

As parent/guardian of \_\_\_\_\_, I give my permission for his/her travel with the Rolling Meadows High School Music Department from July 1, 2017 to June 30, 2018. I am fully aware of District 214 and Rolling Meadows High School Music Department policies concerning student behavior and discipline, and the student for whom I am responsible has been impressed with the importance of those policies. I further agree that in the event of disciplinary action requiring my student to be returned home, I will assume the full cost of the return trip.

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

**EMERGENCY MEDICAL TREATMENT**

As parent/guardian of \_\_\_\_\_, I authorize treatment of the above-mentioned student by a nurse or qualified physician in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual trained in first aid, if, in the opinion of that individual, delay might endanger his/her life, cause disfigurement, physical impairment or undue discomfort. In the Medical Information portion of the form, I have listed any allergies, on-going medical treatment or medical problems that might influence treatment of the student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the understanding that, except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_