

SOUTH WESTERN HIGH SCHOOL BAND

Bill Kirsch, Director

EMERGENCY MEDICAL FORM

Student's Name _____ Grade _____
Address _____ Telephone _____
City _____ State _____ Zip _____ Age _____ Date of Birth _____
Person To Contact _____ Relationship _____
Place of Employment _____ Telephone _____
Family Physician's Name _____ Telephone _____
Name of Insurance Company _____ Policy # _____

*Attach photocopy of Your Insurance Card to Back of This Form

Last Tetanus Shot _____

Food/Drug Allergies (Include allergic reaction): (use back if necessary)

(possible reactions include rash, swelling, gives, dizziness, breathing difficulty, stomach upset, fever, diarrhea, flush or shock)

Table with 2 columns: Allergy, Reaction. Rows 1), 2), 3)

List all current medications and dosage schedules (include Special Needs Medicines)

Table with 3 columns: Medications, Dosage, Reason for Usage. Rows 1), 2), 3)

Other Medical Concern/Vital Info: (use back or separate paper if necessary)

I, the parent/guardian of _____ hereby authorize any necessary basic first aid and/org emergency medical treatment by nurse or school physician or hospital for this child while in the care of the South Western School District. I will assume responsibility for the fees incurred by such an emergency. I also give my permission to share my child's health information with school and medical personnel for the well-being and safety of said child. Furthermore, I authorize my child to receive such school-approved medications as agreed upon and listed on the back of this form and which are given by those who are medically qualified to give such medications.

Date _____ Signature _____
Relationship to student _____

I decline to provide the above information or agree to the above.

Date _____ Signature _____

Please put an “X” over any medication that you do not wish your child to have while attending school events and/or practices. If you do not put an “X” over any medications, it will be assumed that you allow these medications to be given to your child.

Pain Medication – Acetaminophen (Tylenol) or Ibuprofen (Advil, Motrin, Midol)

Upset Stomach/Nausea – Roloids/Tums

Sore /Irritated Throat – Cepacol lozenges

Diarrhea – Loperamide (Imodium)

Severe Allergic Reaction – Diphenhydramine (Benadryl)

Seasonal Allergic Reaction – Generic Claritin

Sinus Pressure – Pseudoephedrine (Sudafed P.E.)

Please list any additional allergies/medications/medical information here

Please tape/scan copy of **front** and **back** of Insurance Card below

Front

Back