Last Name (please print): _____

KELLOGGSVILLE MARCHING BAND
HEALTH FORM

All prescription medications brought to camp must be in their original container, bearing the pharmacy label, showing the prescription number, date filled, physician's name, name of medication, directions for use and patient name. Any over-the-counter medication should be in the original container clearly marked with your child's name.

Student's Name _____ Birth Date _____

Address _____

Parent/Guardian's Name _____ Home Phone _____

Work Phone _____ Cell Phone_____

Parents email address:_____

If not available in an emergency, please notify: (please give 2 names)

1) Emergency Contact Name _____

   Relationship to student _____ Phone _____

2) Emergency Contact Name _____

   Relationship to student _____ Phone _____

Insurance Company _____ Policy Number _____

Family Physician:_____ Phone_____

PARENT/GUARDIAN AUTHORIZATION

I, the undersigned, hereby give full permission for my child, named previously, to attend Olivet College with the Kelloggsville High School Marching Band. I authorize the Olivet College health officer to administer routine medical care. In case of emergency, I hereby give my permission to the licensed physician, selected by the Director of Bands, to hospitalize and/or secure proper treatment for my son/daughter named on this form.

Please Note: The Director of Bands or his designee will contact you upon any emergency

Parent/Guardian Signature _____

Date _____

PLEASE FILL OUT THE INFORMATION ON THE BACK COMPLETELY.

Does your Student require any special dietary needs? (Example: Vegetarian) _____

Is your student under medication that must be administered during camp?(See attached form). ___

Does your student have any other medical problems that we should be aware of? Yes No

If yes, please list: _____

_____

Date of last Tetanus shot: _____

ALLERGIES:

Medication? Yes No If yes, please list:_____

Food? Yes No If yes, please list:_____

Insect Bites? Yes No If yes, please list:_____

What treatment works best on above listed allergies?_____

_____

ASTHMA OR BREATHING PROBLEMS

Does your student have asthma or breathing problems? Yes No

If yes, how is it treated? Please be specific. _____

_____

Frequency of problem?_____

JOINT OR BONE PROBLEMS

Does your student have any history of bone problems? Yes No

If yes, what type? Please be specific. _____

Does he/she require any supports or braces? Yes No

Any Limitations? Yes No

If yes, list? Please be specific. _____

GENERAL

Any history of medical problems in the past year? Yes No

If yes, please list? _____

Has your student had any surgery performed in the past year? Yes No

If yes, please list? _____

NOTE:
PLEASE FILL OUT THE ATTACHED MEDICATION SHEETS.