Montgomery Blair High School
Health History – Page 1 of 4
CONFIDENTIAL

Student's Name: _____ Gender: _____

Date of Birth: _____

Address:
_____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Contact Information

Parent/Guardian 1's Name:

_____

Address:
_____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell/Work #: _____

Parent/Guardian 2's Name:

_____

Address:
_____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell/Work #: _____

Emergency Contact Information

In case of emergency and parent/guardian cannot be reached, contact:

1) _____ Phone #: _____

2) _____ Phone #: _____

Health History (check all that apply)

_____ Asthma _____ Ear Infections _____ Heart Disease _____ Diabetes
_____ Epilepsy _____ Other

Please provide further specific information that may be helpful:

_____

_____

_____

_____

Allergies (check all that apply)

_____ Animal _____ Insect Stings _____ Pollen

_____ Food _____ Medicine/Drugs _____ Other

Please provide further specific information that may be helpful:

_____

_____

Other Health Conditions (check all that apply)

_____Emotional Disturbance_____ Fainting _____ Hearing Impairment

_____ Special Diet _____ Motion Sickness_____ Wears Contacts

_____ Wears Glasses _____ Nosebleeds _____ Other

Please provide further specific information that may be helpful:

_____

_____

Immunizations (please give dates of last immunization)

Tetanus: _____ MMR: _____ Hepatitis B: _____

Is your child under the care of a physician?

_____Yes _____No

Does your child have a condition requiring regular medication?

_____Yes _____No

Is there any restriction on your child's activities? _____Yes _____No

If you answered "yes" to any of the above questions, please provide specific information that may be helpful:

_____

_____

_____

_____

_____

I am the parent/guardian of _____. Should a medical emergency arise during my child's participation in a MBHS Band activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers listed below. If it is believed that my child's life or health may be adversely affected by the delay that an attempt to contact me or my alternate would cause, I consent to:

1) The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or the medical facility identified below or chosen by the adult in charge; and

2) The immediate administration of life-saving measures deemed necessary under the circumstances.

Insurance Information

Insurance Company: _____

Group Number: _____

PolicyNumber:_____ PolicyHolder'sName:_____

If I cannot be reached in the event of an emergency, the following person is authorized to act in my behalf:

Designated Alternate's Name:_____

Relationship to Student: _____ Phone(s):_____

Preferred Medical Doctor/Medical Facility:

_____

Doctor's Phone Number: _____

_____ _____

Signature of Parent/Guardian Date