

NORTH OCONEE HIGH SCHOOL TITAN REGIMENT

Medical Form: 2018-2019

Student's Name _____ Grade _____

Date of Birth _____ Age (As of July 16th) _____

Home Address _____
Street or P.O. Box City ZIP

Father's Name _____ Cell Phone _____

Mother's Name _____ Cell Phone _____

In the event a parent/guardian cannot be reached, who should be contacted in case of an emergency?

Name/Relation: _____ Name/Relation: _____
 Phone: _____ Phone: _____

Insurance Carrier: _____ Policy Number: _____

Insurance Phone: _____ Group Number: _____

Physician Name: _____ Phone: _____

List ALL Medications: _____ Check if NONE _____

List ALL Allergies: _____ Check if NONE _____

Please check any conditions below that apply:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Menstrual disorder	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stomach problems	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Gall bladder disorder	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chronic rash
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Mumps	

Is there any additional information we need to know? (Explain on back of sheet) Yes ___ No ___

I give permission for the band's first aid personnel to administer the following over-the-counter medications as needed: (Please circle YES or NO for each medication listed.)

Ibuprofen	YES	NO	<i>Antihistamines:</i>		Pepto Bismol	YES	NO	
Acetaminophen	YES	NO	Oral	YES	NO	Tums	YES	NO
Cough Syrup	YES	NO	Topical	YES	NO	Bug Repellant (containing DEET)	YES	NO
						Dramamine (on bus trips)	YES	NO

I understand that in the event that a parent or guardian cannot be reached or immediate attention is required, the North Oconee band or any of its designated volunteers has my permission to seek appropriate medical attention. I understand that I am legally responsible for any financial obligations incurred in the emergency treatment of my child. It is the parent's/guardian's responsibility to update this record if necessary.

Parent/Guardian Signature: _____ Date: _____
Parents must sign regardless of student's age!

PERMISSIONS:

1. I give permission to include any pictures containing my child to be published on the Band website or other publications YES NO Initials: _____
 2. I give permission for my student to travel with the NOHS band YES NO Initials: _____
- (Additional permission forms may apply)