

**NORTH OCONEE HIGH SCHOOL TITAN REGIMENT**  
**Medical Form: 2020-2021**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age (As of July 20th) \_\_\_\_\_  
 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:**

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