Vidalia Band Boosters

Medical Information Sheet

2014-2015

**STUDENT INFORMATION:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_Zip \_\_\_\_\_\_\_\_

Student Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_ Student Cell Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male\_\_\_\_ Female\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:**

Father’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance company name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father or Mother’s Insurance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person to contact in case of emergency** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following questions, please circle yes or no. **Your answers are for our records only and will be kept confidential.**

1). Are you in good health? ………………………………………….…………………………………………………………………………….YES NO

2). Are you taking any medication(s) on a regular basis? …………………………………………………..……………………….YES NO

2A). If yes, please list medicines you are currently taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3). Do you have or have you had any of the following diseases or problems?

A). Heart trouble or High blood pressure ……………………………………………………………………………………………….YES NO

B). Allergy …………………..………………………………………………………………………………………………………………………….YES NO

C). Sinus trouble …………………………………………………………………………………………………………………………………….YES NO

D). Asthma or Hay Fever …………………………………………………….………………………………………………………………….YES NO

E). Fainting Spells or Seizures ………………………………………..……………………………………………………………………….YES NO

F). Diabetes ……………………………………..…………………………………………………………………………………………………….YES NO

G). Hepatitis or Jaundice ……………………………….……………………………………………………………………………………….YES NO

H). Respiratory problems (bronchitis, etc.) …………………………………………………………………………………………….YES NO

I). Stomach Ulcer or hyperacidity ………………….……………………………………………………………………………………….YES NO

J). Kidney trouble ……………………………………………….………………………………………………………………………………….YES NO

K). Low blood pressure …………………………………………….…………………………………………………………………………….YES NO

L). Sexually transmitted disease …………………………………………………………………………………………………………….YES NO

M). Epilepsy ……………………………….………………………………………………………………………………………………………….YES NO

N). Problems of the immune system …………………………….……………………………………………………………………….YES NO

4). Have you ever had a blood transfusion? ……………………………………………………………………………………………….YES NO

5). Do you have any blood disorder such as anemia? ………………………..……………………………………………………….YES NO

6). Are you allergic or have you had a reaction to

A). Local anesthetics ………………………………………………..…………………………………………………………………………….YES NO

B). Penicillin or other antibiotics …………………………………………………………………………………………………………….YES NO

C). Sulfa drugs ……………………………….……………………………………………………………………………………………………….YES NO

D). Barbiturates or sedatives ………………………………………………………………………………………………………………….YES NO

E). Aspirin ………………………………………..…………………………………………………………………………………………………….YES NO

F). Iodine ……………………………………………………………………………………………………………………………………………….YES NO

G). Codeine or other narcotics ……………………………………………………………………………………………………………….YES NO

H). Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7). Are you up to date on your immunization shots? …………………………………………………………………………………YES NO

8). Do you have any disease, condition, or problem not listed above that you think we should know about? \_\_\_\_\_\_

If so, explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE STUDENTS ONLY**

1). Are you pregnant? ………………………………………………………………………..………………………………………………………YES NO

2). Are you taking birth control pills? …………………………………………………..…………………………………………………….YES NO

3). Are you having problems with:

A). Anorexia? ............................................................................................................................................ YES NO

B). Bulimia? ……………………………………………………………………………..…………………………………………………………..YES NO

4). Are you taking diuretics (diet pills)? ……………………………………….….………………………………………………………..YES NO

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the VIDALIA BAND BOOSTERS responsible for any errors or omissions that I may have made in completion of this form.

**MEDICAL RELEASE**

In the event of an emergency where medical attention is required, I hereby give my permission to the VIDALIA BAND BOOSTERS to obtain the services of a licensed physician. And I will not hold theVIDALIA BAND BOOSTERS responsible for any actions beyond their control.

PARENT/ GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_