

# Holly Springs High School Band Student Health History

Student's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ Birth Date: \_\_\_\_\_ Grade (Fall): \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical History (give dates where known):

Operations: \_\_\_\_\_

Emotional Problems (hysteria, hyperventilation, depression, etc.): \_\_\_\_\_

Serious Medical Problems: \_\_\_\_\_

Contact Lenses, Braces/Retainers, or Other Prosthetic Devices: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Epilepsy: \_\_\_\_\_ Asthma: \_\_\_\_\_ Last Tetanus Injection: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Will student be taking medication(s) on his/her own? If so, please list: \_\_\_\_\_

Please list any special health problems in the past: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

*Please note any special instructions regarding insurance/approval requirements.*

This is permission for the treatment of a child by a physician and at a hospital for any medical or surgical emergency.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notary Witness

\_\_\_\_\_  
Date