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