

**CENTRAL-CARROLL HIGH SCHOOL BANDS  
2011-2012 MEDICAL FORM**

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_

LEGAL GUARDIAN \_\_\_\_\_

WHO DOES STUDENT RESIDE WITH? \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE NUMBER (     ) \_\_\_\_\_

MOTHER'S PLACE OF EMPLOYMENT \_\_\_\_\_

FATHER'S PLACE OF EMPLOYMENT \_\_\_\_\_

M-WORK PHONE \_\_\_\_\_ F-WORK PHONE \_\_\_\_\_

M-CELL PHONE \_\_\_\_\_ F-CELL PHONE \_\_\_\_\_

EMERGENCY CONTACT NAME AND PHONE NUMBER \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURANCE PHONE NUMBER \_\_\_\_\_

MEDICAID# \_\_\_\_\_

PEACHCARE INFO. NAME AND NUMBER \_\_\_\_\_

**MEDICAL HISTORY: CHECK ALL THAT APPLY**

\_\_\_ ASTHMA

\_\_\_ HIGH BLOOD PRESSURE

\_\_\_ ANXIETY DISORDER

\_\_\_ BLEEDING DISORDER

\_\_\_ DEPRESSION

\_\_\_ MUSCLE BONE OR JOINT DISORDERS

\_\_\_ REFLUX OR ULCERS

\_\_\_ DIABETES

\_\_\_ SEIZURES

\_\_\_ ULCERS

\_\_\_ MIGRAINE/HEADACHES

**Complete Other Side**

ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE \_\_\_\_\_

EXPLAIN **CURRENT** MEDICAL TREATMENT FOR ANY OF THE ABOVE MEDICAL CONDITIONS (EXAMPLE: MEDICATIONS OR SPECIAL NEEDS)

ALLERGIES (DRUGS, FOOD, INSECTS AND ENVIROMENTTAL) AND SPECIAL TREATMENT NECESSARY FOR THE ABOVE ALLERGIES (DO YOU CARRY AN EIPEN FOR ANY OF YOUR ALLERGIES)

**\*PLEASE NOTE, WE DO NOT HAVE OR PROVIDE EPIPENS.**

MAY WE ADMINISTER OVER THE COUNTER MEDICATIONS TO YOUR CHILD? Yes No

ARE THERE ANY SPECIFIC OVER THE COUNTER MEDICATION THAT YOU **DO NOT WANT** ADMINISTERED TO YOUR CHILD? (Tylenol, Advil, Imodium, etc.)

PHYSICIAN'S NAME \_\_\_\_\_

PHYSICIAN'S PHONE NUMBER ( ) \_\_\_\_\_

**IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO DISCLOSE ANY CHANGE IN MEDICAL CONDITION OR MEDICATION TO THE BAND OFFICE AS SOON AS POSSIBLE**

IN THE EVENT THAT A MEDICAL EMERGENCY OCCURS, I GIVE MY PERMISSION TO SEEK MEDICAL ATTENTION FOR MY CHILD.

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_