CENTRAL-CARROLL HIGH SCHOOL BANDS
2020-2021 MEDICAL FORM

NAME:_____ DATE OF BIRTH _____

MOTHER'S NAME:_____ FATHER'S NAME:_____

LEGAL GUARDIAN_____HOME PHONE NUMBER ( ) _____

WHO DOES STUDENT RESIDE WITH? _____

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP_____

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 _____

INSURANCE CARD (both sides):

_____ **CHECK HERE IF NO INSURANCE**

Complete Other Side:

STUDENT NAME _____

MEDICAL HISTORY: CHECK ALL THAT APPLY AND CIRCLE

____ASTHMA	____REFLUX OR ULCERS
____HIGH BLOOD PRESSURE	____DIABETES/LOW BLOOD SUGAR
____ANXIETY DISORDER/DEPRESSION	____SEIZURES
____BLEEDING DISORDER	____HEART DISORDER
____RECENT SURGICAL HISTORY	____MIGRAINE/HEADACHES
____MUSCLE, BONE, OR JOINT DISORDERS	____PSYCHIATRIC DISORDERS
____FREQUENT NOSEBLEEDS	____SEIZURES/EPILEPSEY
____HEADACHES	____KIDNEY DISORDERS

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 ENVIROMENTAL) AND SPECIAL TREATMENT NECESSARY FOR THE ABOVE ALLERGIES (DO YOU CARRY AN EPIPEN 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

DOES YOUR STUDENT SUFFER FROM MOTION SICKNESS? Yes No

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

_____
_____
_____

PHYSICIAN'S NAME _____
PHYSICIAN 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_____