Manzano Band Health Waiver, 2019-2020

This is to be completed, signed by a parent/guardian

Student Name ______________________ Birthdate ____________ Grade ____________
Home (physical) address ______________________ City ____________ ZIP ____________
Mailing address (if different) ______________________ City ____________ ZIP ____________
Student Email Address: ______________________ Home Phone# ____________
Student Cell Phone # ____________ Accept Text? ☐Yes ☐No
Parent/ Guardian Name: ____________ Parent/ Guardian Phone# ____________
Parent Cell Phone # ____________ Accept Text? ☐Yes ☐No
Parent/Guardian Email Address: ______________________
Additional Emergency Contact(s):
Name: ____________ Relationship: ____________ Home Phone ____________ Cell: ____________
Name: ____________ Relationship: ____________ Home Phone ____________ Cell: ____________
Which Band groups do you participate in (Check all that apply):
☐Marching; ☐Concert(Symphonic/Wind Ensemble); ☐Jazz; ☐Colorguard; ☐Winterguard;
What instruments do you play? ______________________
Any Special food needs? ______________________

PART I: **Date of last Tetanus Shot**____________

Illnesses and injuries (check those that apply)

Chronic or recurring illness:

☐Asthma ☐Diabetes ☐Seizures ☐Kidney Disease ☐Hypertension ☐ Ear Infection
☐ Skin/Muscle Disorders ☐ Heart Disease ☐ Bleeding/Clotting Disorder ☐ Sickle cell trait or disease
☐ Other ______________________

Please Check Yes or No to the following questions and explain all "yes" answers include dates:	**YES**	**NO**
Were any complicating medical problems noted in your student's last examination?	☐	☐
What: ______________________		
Is your student currently under a physician's care for a medical problem?	☐	☐
What For: ______________________		
A serious injury requiring medical attention **Injury:** ____________ **Date:** ________	☐	☐
An illness lasting longer than one week? **Diagnosis:** ____________ **Date:** ________	☐	☐
A surgical operation or bone fracture? **Type:** ____________ **Date:** ________	☐	☐
Have you ever been diagnosed with asthma**:** **Date** ____________	☐	☐
Do you have trouble breathing **and/or** cough during or after activity?	☐	☐

PART II: **Allergies (check those that apply)** Do you carry an Epi-Pen? ☐**Yes** ☐**No**

☐ Animals (specify) ____________ ☐ Medicine/drugs (specify)____________
☐ Food (specify)____________ ☐ Plants (specify) ____________
☐ Hay fever ☐ Insect Stings (specify) ____________ ☐ Other (specify ____________

Please describe allergic reaction to any "checked" answers above. Indicate any information useful to the adult in charge in relation to any of these allergies and your student's reactions.

____

PART III: **Other health conditions (check those that apply)**

☐hearing impairment ☐menstrual cramps ☐special diet ☐sleep disturbances
☐emotional problems ☐motion sickness ☐wears contact lenses
☐fainting ☐nosebleeds ☐wears glasses
☐other (specify) ______________________

Please explain any "checked" answers above. Indicate any information useful to the adult in charge in relation to any of these health conditions. Indicate any activity to be encouraged or restricted:

PART IV: **Medication**

Please check all medications in with the appropriate chaperone; this includes inhalers, epi-pens, prescription meds, and over-the-counter meds. Once medication is checked in students will be allowed to carry emergency medication (e.g., inhalers and epi-pens).

Do you carry an inhaler? ☐**Yes** ☐**No**

What Type____

Please send your child's inhaler even if they have had no recent asthma/breathing attacks

Medication prescribed by a doctor to be taken on a regular basis? ☐**Yes** ☐**No**

List Medication and times to be given: ________________________________

____

____

Additional medications provided by the parents to be given as needed. ☐**Yes** ☐**No**

List: ____

____

Chaperones have my permission to give my child over-the-counter medications if needed (e.g.,Tylenol, Ibuprofen, Antacids, Cough drops, Midol, Lactase Tablets) ☐**Yes** ☐**No**

Chaperones have my permission to give my child over the counter medications if needed for allergic symptoms (e.g.,. Benadryl, Zyrtex) ☐**Yes** ☐ **No**

I understand that I am responsible in providing all Prescription medication that my child takes daily to the designated chaperone prior to trip departure. All prescription medication should be in the original pharmacy labeled bottle.

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Signature of Parent/Guardian Date

PART V: **Emergency Information**

Family medical/hospital: ____

Policy or Insurance carrier:___________________________Group No:____________

Name of family physician:___________________________Phone: _____________

IN CASE OF MEDICAL EMERGENCY, I understand that when medically feasible, an effort will be made to contact a parent or guardian, but in the event one is not reached or if it is not medically feasible to contact one, I hereby give permission for my student to be treated.

____

Signature of Parent/Guardian Date

I know of no reason(s) other than the information indicated on this form why my student should not participate in prescribed activities except as noted.

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Signature of Parent/Guardian Date