Manzano Band Health Waiver, 2021-2022

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:

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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.

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.

Signature of Parent/Guardian Date