

McKENDREE UNIVERSITY BANDS STUDENT HEALTH HISTORY FORM

Please print clearly OR type in the spaces provided and maintain the current format. Thanks.

STUDENT NAME _____ DATE OF BIRTH _____

PARENT/GUARDIAN #1 _____ HOME PHONE # _____

ADDRESS, CITY _____ BUSINESS PHONE # _____

PARENT/GUARDIAN #2 _____ HOME PHONE # _____

ADDRESS, CITY _____ BUSINESS PHONE # _____

EMERGENCY CONTACT (other than parent) _____

RELATIONSHIP _____ PHONE # _____

FAMILY PHYSICIAN _____ OFFICE PHONE # _____

HEALTH HISTORY: (please give dates where known) *COMPLETE ON ADDITIONAL PAPER IF NEEDED*

OPERATION (within the last 2 years) _____ RHEUMATIC FEVER _____

EMOTIONAL PROBLEMS (i.e. hyperventilation, hysteria) _____

SERIOUS MEDICAL PROBLEMS _____ MEDICATION _____

DIABETES _____ NAME OF INSULIN TAKEN, AMOUNT AND TIME _____

EPILEPSY _____ MEDICATION TAKEN, AMOUNT AND TIME _____

TRANQUILIZERS ___ ALLERGY TO DRUGS (specify i.e. penicillin, insulin, sulfa, etc.) _____

ARE YOU PRESENTLY UNDER TREATMENT FOR ANY MEDICAL PROBLEMS IF YES, PLEASE

IDENTIFY: ___yes ___no _____

PLEASE LIST ANY ALLERGIES (specify i.e. latex, peanut butter, bee stings, etc.)

PHYSICAL CONDITIONS WHICH MAY LIMIT MARCHING BAND ACTIVITIES? IF YES, PLEASE IDENTIFY:

___yes ___no _____

PLEASE LIST ANY OTHER MEDICATIONS YOU ARE TAKING:

CAN TAKE AND HAVE APPROVAL TO TAKE: ___ASPIRIN ___TYLENOL

___MOTION SICKNESS MEDICINE

DATE OF LAST TETANUS SHOT: _____

SPECIAL DIETARY NEEDS? IF YES, PLEASE CHECK AND IDENTIFY: ___yes ___no _____

**McKENDREE UNIVERSITY BANDS
TRAVEL CONSENT / MEDICAL RELEASE FORM**

TRAVEL CONSENT

As parent/guardian of _____, I give my permission for his / her
(name of student)

travel with the McKendree University Music Department from August 1, 2009 to August 1, 2010. I am fully aware of McKendree College's policies concerning student behavior and discipline. I further agree that in the even of disciplinary action requiring my student to be returned home, I will assume the full cost of the return trip.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

EMERGENCY MEDICAL TREATMENT

As parent / guardian of _____, I authorize treatment of the
(name of student)

above-mentioned student by a nurse or qualified physician in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, the initial treatment of the student may be rendered by an individual trained in first aid, if in the opinion of that individual, delay might endanger his/her life, cause disfigurement, physical impairment or undue discomfort. In the Medical Information portion of the form, I have listed any allergies, on-going medical treatment or medical problems which might influence treatment of the student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the understanding that, except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

**STUDENTS COVERED BY GROUP OR OTHER MEDICAL INSURANCE AS
FOLLOWS:**

NAME OF INSURED: _____

INSURANCE COMPANY: _____

GROUP #: _____

POLICY #: _____

STUDENTS WHO ARE OVER 18 YEARS OF AGE MAY SIGN THE TRAVEL CONSENT AND EMERGENCY MEDICAL TREATMENT FORMS WITHOUT PARENTAL CONSENT, HOWEVER, WE ENCOURAGE STUDENTS TO HAVE PARENTS SIGN AS WELL IF YOU ARE BEING COVERED BY YOUR PARENTS' INSURANCE. THIS MAY HELP AVOID LEGAL ISSUES LATER ON WITH YOUR HEALTH INSURANCE COMPANY SHOULD EMERGENCY TREATMENT BE NECESSARY.