Spring Valley High School Band
Emergency Medical and Surgical Permit

Personal Information

Name:_____
Last Name First Name M.I.
Address:_____
Street City State Zip
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Date of Birth_____ Sex: M F

Emergency Contact Information:

_____
Name Phone(s) Relationship

Medical Information

Local Physician_____
Name Address Phone
Current Medications (Rx or OTC) list and give dosages:
_____
_____
Known Allergies: _____
_____
Date of last Tetanus Shot:_____
Any restrictions on activities? (Describe)_____
_____

Insurance Information

Hospitalization Policy:_____
Group Number:_____Policy/Certificate Number:_____

Please provide any additional information you feel the band director(s) and/or chaperones should be aware of:_____
_____

I hereby consent for a qualified physician to perform any medical or surgical procedure deemed advisable to the welfare of the applicant while he/she is participating or traveling with the Spring Valley High School Band. Further, this authorization permits said physician to hospitalize, to secure necessary and appropriate consultation, to order injections, anesthesia (local, general or both) and/or surgery for this applicant. I do hereby assume and agree to pay for any indebtedness for physician(s) fees and hospital fees for such services.

Signed:_____Date:_____

Notary:_____My commission expires:_____
PLEASE ATTACH A COPY OF INSURANCE CARD

HEALTH HISTORY: Please check and explain all health problems diagnosed by a physician.

ADD___ADHD_____	Digestive problem_____	Leukemia_____
Allergies--seasonal_____	Down's Syndrome_____	Liver problems_____
bees_____foods_____	Emotional Problems_____	Migraines_____
Arthritis_____	_____	Headaches(freq)_____
Asthma--mild____mod____	GERD_____	Seizures_____Type_____
severe_____	Hearing problems_____	Date of last seizure_____
Autism_____	Aides_____	Scoliosis_____
Cancer_____	Heart Problem_____	Spina Bifida_____
Type_____	Murmur_____Surgery_____	Shunt_____
Cerebral Palsy_____	Hemophilia_____	Tourette's_____
Chronic ear infections_____	Hypertension_____	Vision problems_____
Tubes_____	Medication_____	Glasses--Far____Near____
Cystic Fibrosis_____	Hypoglycemia_____	Other_____
Diabetes - Type_____	Kidney problems_____	_____
Insulin: Pump_____Injection_____	Catheterization_____	Does your child have:
Glucoscan at school_____		Medicaid_____CHIPS_____

Explanation of Health Conditions/Problems:

_____

_____

_____

Do you have a **SEVERE REACTION TO BEE STINGS** or **FOODS REQUIRING USE OF AN EPIPEN?**
YES_____ NO_____

SIGNATURE:_____DATE:_____