AUBURN HIGH SCHOOL BAND
MEDICAL FORM

Please complete and return to Mr. Cothran.

STUDENT'S NAME _____ BIRTH DATE _____
ADDRESS _____ PHONE ( ) _____
CITY _____ STATE_____ ZIP CODE _____
EMERGENCY NAMES AND PHONE NUMBERS
1. _____
2. _____

HEALTH HISTORY (Please check those that apply)	ALLERGIES
HEART DEFECT/DISEASE	HAY FEVER
SEIZURES	INSECT
STINGS/BITES	
DIABETES	
PENICILLIN	
BLOOD CLOTTING DISORDERS	OTHER DRUGS (list)

OTHER _____
CHRONIC OR RECURRING ILLNESS (Please explain) _____
_____
MEDICINE THAT STUDENT NEEDS TO TAKE _____
NAME OF FAMILY PHYSICIAN _____ PHONE _____
DO YOU CARRY FAMILY MEDICAL/HOSPITAL INSURANCE? YES NO
IF SO INDICATE: CARRIER _____
POLICY OR GROUP NUMBER _____
IMPORTANT: PLEASE NOTIFY THE BAND DIRECTORS IF THIS BAND MEMBER HAS BEEN EXPOSED TO ANY COMMUNICABLE DISEASES DURING THE 3 WEEKS PRIOR TO ANY BAND FUNCTION.

PARENT'S AUTHORIZATION: THIS HEALTH HISTORY IS CORRECT IN SO FAR AS I KNOW. I HEREBY GIVE MY PERMISSION TO THE PHYSICIAN TO ORDER X-RAYS, ROUTINE TESTS AND TREATMENT FOR THE HEALTH OF MY CHILD/WARD. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE BAND DIRECTORS AND/OR THEIR REPRESENTATIVE TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER INJECTION AND/OR ANESTHESIA AND/OR SURGERY TO THE BAND MEMBER NAMED ABOVE.

PARENT OR GUARDIAN SIGNATURES

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