DOWLING CATHOLIC VANGUARD

2018-2019 Medical Information Form

Student Name: _____ Section/Instrument: _____
Grade (2018-2019): _____ Birth Date: _____
Address: _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____

Relative other than those listed above or an emergency contact:
Name: _____
Relationship: _____ Phone: _____

Healthcare Providers

Physician: _____ Phone: _____
Dentist: _____ Phone: _____

Insurance Information

Health Insurance: _____ Policy #: _____
Policy Holder: _____ Policy Holder's Birthdate: _____

Medical History

Past or present major disease, serious illness, or injury? ☐ No ☐ Yes (specify below)

List illness, disease, injury including year in which it occurred: _____
_____
_____
_____

☐ Allergy (specify)
Food: _____
Meds.: _____
Enviro.: _____
☐ Asthma
☐ Bleeding Disorder
☐ Contact Lenses
☐ Dental Problems
☐ Diabetes
☐ Fainting
☐ Heart Condition
☐ High Blood Pressure
☐ Kidney Problems
☐ Seizures
☐ Sleep walking
☐ Headaches
☐ Surgery
☐ Other

Explain items checked: _____
_____
_____
_____

Any condition that may require special care, education, or diet: _____
_____
_____
_____

This form is **mandatory** and must be turned in no later than August 1st. Students will not be allowed to participate in Band Camp unless their medical form is on file.

2018-2019 Medical Information Form

Student's name: _____

Release

If parents and authorized physician or dentist cannot be reached at the time of emergency and if immediate treatment is urgent in the perception of school authorities, I request, authorize and will be responsible for necessary emergency medical care. Our physician or dentist may be contacted and is authorized to release requested information. I understand that the chaperones will endeavor to safeguard the health and safety of each student but will, in no way, be held responsible in case of accident or illness.

_____ _____

Parent/Guardian (must be signed) Date

Over-the-Counter Medications

Please note, we cannot be responsible for medications given to your student by another student. I authorize chaperones to administer over-the-counter medications as directed in the event of minor illness (e.g., Tylenol, Ibuprofen, Imodium, Dramamine, Benadryl, cold medications or Antacids).

☐ Yes ☐ No

Exceptions: _____

_____ _____

Parent/Guardian (must be signed) Date

Authorization to Administer Medication

This must be signed by a parent/guardian to authorize administration of any medication being sent for the student. Medications must be in original labeled containers. Students will be allowed to self-administer asthma inhalers and eye medications. List all medications and non-prescription items such as vitamins and herbal supplements.

Medication	Dosage	No. of doses/day	Time	No. of Days

I request the prescribed medication to be administered according to the above written directions.

_____ _____

Parent/Guardian (must be signed) Date

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