Greenwood Band Department
Greenwood Community Schools

****MUST BE NOTARIZED!!**

Student Health Record

Part I: General Information

Student Name _____

Date of Birth_____ **Place of Birth** _____

Home Address_____**Zip Code**_____

Home Phone _____ **Parent Cell Phone** _____

Emergency Name and Phone _____

Doctor's Name and Phone _____

Dentist's Name and Phone _____

Hospital of Choice if Possible _____

Insurance Company _____

Policy Number or Card Number _____

Part II: Health History

Does your child have any of the following diseases or problems, if yes, what year?

Asthma _____	**Hepatitis** _____	**Seizures** _____
Hay Fever _____	**Fainting** _____	**Knee Injury** ___
Pneumonia _____	**Frequent Headaches** ___	**Head Injury** __
Bronchitis _____	**Frequent Earaches** __	**Back Injury** ___
Rheumatic Fever _____	**Frequent Sore Throat** __	**Diabetes** ___
Ulcers - where _____	**Tonsillitis** _____	**Other** ____
Flat Feet _____	**Tubes in Ears** ____	___
High Blood Pressure _____	**Hyperventilation** ____	___

If you checked any item in the third column, please explain.
List all allergies, and irritants; include all allergies to medicine, food, bee stings, etc.
Is the above student taking any sustaining medication? _____ yes _____ no
If yes, please describe full the medication and any possible reactions.
Is the above student in need of any dietary considerations? _____ yes _____no
If yes, please describe _____
Have glasses been prescribed for this student? _____ yes _____ no
When are they to be worn? _____
Does this student wear contact lenses? _____ yes _____ no
Is there any history of diabetes, heart disease, stroke, high blood pressure, cancer, tuberculosis, or any condition that is said to "run in the family"? If so, please identify the condition and give the relationship.

(over)

Part III: Consent

This is a medical authorization by parents for another to consent to hospitalization, surgery or special medical procedures during the absence of parents.

Parent Name (please print):_____
First Last
Parent Name (please print):_____
First Last
Student Name (please print):_____
First Last

We hereby appoint the Greenwood Band Staff as the persons, individually or collectively, who, during those periods of time when my/our above named child is participating or engaged in the activities of the Greenwood Community School Corporation Band program. (PROGRAM) shall be authorized to consent for all medical/and or surgical treatment and/or special procedures (including by way of illustration and not limitation, administration of anesthesia, blood transfusions, diagnostic tests, dental or optical treatments, etc.) which may be required during participation in the PROGRAM.

Any hospital, its officers and personnel and any physician/dentist authorized and licensed to practice medical or surgical services to any child named above may rely upon the consent of authorization executed by the above named appointee with the same force and effect as if personally executed by us.

The consent and authorization shall include and extend to all matters for which consent and authorization is required under the policies of the hospital. In consideration of the services which are rendered to any child named above, pursuant hereto, we agree to pay for all such services. This authorization shall be effective until

a) (date)_____ or b) until revoked in writing. (Strike out inapplicable term.)

Parent Signature _____ Parent Signature_____

In the event that this form is executed by only one parent, please state below the reason why the signature of the other parent cannot be obtained. _____
_____

If the child is under guardianship, the guardian should execute this authorization.

STATE OF INDIANA)
) SS:
COUNTY OF)

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

Notary Public, _____

Resident of _____ County, Indiana

My Commission Expires: _____

(over)