



MHS Band Medical History Form

P. O. Box 496, Morgantown, WV 26507-0496

Student's Name: _____ Date of Birth ___/___/___
(Please Print) Last First Middle

Home Address _____ Student's Cell# _____

Medical conditions: (check all that apply)	Allergies: (please describe serious allergies & treatment on back)
<input type="checkbox"/> Asthma (list treatment below)	<input type="checkbox"/> Medicine life threatening? No /Yes (describe on back)
<input type="checkbox"/> Cardiac (list medication below)	<input type="checkbox"/> Insect Bites life threatening? No /Yes (describe on back)
<input type="checkbox"/> Seizures (list medication below)	<input type="checkbox"/> Latex life threatening? No /Yes (describe on back)
<input type="checkbox"/> Diabetes (list treatment below)	<input type="checkbox"/> Food life threatening? No /Yes (describe on back)
<input type="checkbox"/> Orthopedic (list treatment below)	<input type="checkbox"/> Pollen/environmental
<input type="checkbox"/> Other (explain) _____	<input type="checkbox"/> Other (Please explain on back)
Date of last tetanus shot _____	

Current medications/treatments: Name, Dose, Frequency

Band member can take his/her own medications? Yes No

Do you know of any health factors that make it advisable for your child to follow a limited program of physical activity? No Yes, explain: _____

We have permission to administer to your child: (check all that apply)			
<input type="checkbox"/> Tums, Pepto-Bismol	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Aleve
<input type="checkbox"/> Dramamine	<input type="checkbox"/> Anbesol for mouth pain	<input type="checkbox"/> Sore throat lozenges	<input type="checkbox"/> Benadryl
<input type="checkbox"/> Abreva for cold sores	<input type="checkbox"/> Lubricating Eye drops	<input type="checkbox"/> Sunscreen	

Contact information			
Primary Care Provider _____	MD/DO/NP	Phone # _____	
Parent/Guardian Name: _____	Home # _____	Cell# _____	
Employer _____	Work # _____		
Parent/Guardian Name: _____	Home # _____	Cell# _____	
Employer _____	Work # _____		
Emergency contact: _____	Home # _____	Cell# _____	

Health Insurance information
Company: _____ Policy # _____

In accordance with the rules of the WVSSAC, I give my consent and approval to the participation for the student named above to participate in the MHS Band and I also give my consent for the physician or nurse in attendance and the appropriate medical staff to give treatment at any band event for any injury.	
Parent/Guardian Signature _____	Date _____