

EMERGENCY INFORMATION FORM
North High School Band

Student's Name: _____

Parent/Guardian's Name: _____

Parent/Guardian's Phone Number: Home: _____ Cell: _____

In case Parent/Guardian cannot be reached, notify: _____

Name (& Relationship): _____

Phone #: _____

My child is covered by medical insurance: YES NO

Insurance Company Name: _____

Policy #: _____

Group #: _____

Name of Insured: _____

Phone Number of Company: _____

HEALTH INFORMATION

Does your child have any of the following conditions or a history of any of the following conditions?

- | | |
|---|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart or cardio-vascular problems _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Convulsions/seizure _____ |
| <input type="checkbox"/> Fainting spells _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Chronic bone, muscle or joint injuries _____ | <input type="checkbox"/> Other condition(s): (Please list: _____) |
| <input type="checkbox"/> Migraine headaches _____ | _____ |

Allergies or reactions: *(Check all that apply)*

- Aspirin Penicillin Dairy Gluten Peanuts Insect bites or stings Ivy/oak/sumac toxins
 Other (list) _____

Date of last tetanus shot *(approximate if necessary)*: _____

Is your child currently on any prescribed or over-the-counter medication?

(If so, please record the condition/ailment, name of medication, dosage, time(s) of day, prescribing physician.)

Parent or Guardian Print: _____

Parent or Guardian Signature: _____

Date _____