



North Allegheny School District
MEDICAL INFORMATION AND RELEASE FORM

Student's Last Name _____ First Name _____ MI _____

Grade _____ Date of Birth _____

Address _____

FAMILY INFORMATION

Home Phone # _____ Parent(s)/Guardian(s) Cell # _____

Parent(s)/Guardian(s) Names _____

Work Phone #s _____

Family Physician _____ Office Phone # _____

Please list the name and phone number of two parties who may be called if the parent/guardian may not be reached:

Name _____ Phone # _____

Name _____ Phone # _____

STUDENT MEDICAL INFORMATION

All health concerns of the above named student, past and present, which may limit physical activity, be aggravated or worsened by physical activity, and/or must be known in the treatment of illness or injury must be indicated below. All students' medical information will be kept in strict confidence by the orchestra nurse and school district staff. Please check below if the above named student has or has had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Chronic knee problem | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Hyperventilation |
| <input type="checkbox"/> Chronic ankle problem | <input type="checkbox"/> History of epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chronic back problems | <input type="checkbox"/> History of diabetes | <input type="checkbox"/> Heart related problems |
| <input type="checkbox"/> Chronic foot problems | <input type="checkbox"/> GI disorder/problem | <input type="checkbox"/> Drug allergies |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Metabolic/thyroid | <input type="checkbox"/> Bee sting allergy |
| <input type="checkbox"/> Other | | |

If any of the above items have been checked, please provide a complete explanation. Attach a separate page if necessary.

* PLEASE TURN OVER *

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING ON A REGULAR BASIS:

Medication _____ Dosage _____

When taken (time of day) _____ Physician Prescribing _____

Medication _____ Dosage _____

When taken (time of day) _____ Physician Prescribing _____

Medication _____ Dosage _____

When taken (time of day) _____ Physician Prescribing _____

Date of student's last tetanus shot _____

Medical Insurance Company _____ Agreement # _____

Insurance Company Address _____

***Please attach a small STUDENT PHOTO.
You DO NOT need to attach a copy of your insurance card.***

OVER THE COUNTER MEDICATION LIST:

I give permission to the orchestra nurse to provide for my student the following OTC medications and/or treatments to be offered at the nurse's discretion or by my direction:

<input type="checkbox"/> Antihistamine i.e. Benadryl	<input type="checkbox"/> Decongestant i.e. Sudafed	<input type="checkbox"/> Aleve
<input type="checkbox"/> Acetaminophen i.e. Tylenol	<input type="checkbox"/> Ibuprofen i.e. Advil/Motrin	<input type="checkbox"/> Tums
<input type="checkbox"/> Antacid i.e. Pepcid, Tagament	<input type="checkbox"/> Premenstrual tablet i.e. Midol	<input type="checkbox"/> Cough drops
<input type="checkbox"/> No OTC medications are to be given		

I understand that no OTC medications will be offered to my student if I have not given my consent no matter the degree of discomfort.

I/We hereby authorize representatives of North Allegheny School District to act as my/our agent to secure medical emergency treatment for the above-named student. I/We further agree to hold the North Allegheny School District and its representatives harmless for exercising its judgment in authorizing such emergency medical treatment, and said representatives are specifically authorized to sign any required emergency hospital treatment forms on our behalf.

Parent/Guardian Signature _____ Date _____

**PLEASE RETURN THIS FORM WITH A STUDENT PHOTO
TO THE ORCHESTRA DIRECTOR BY **FRIDAY, SEPTEMBER 9, 2011.****