

Montgomery Blair High School
Health History - Page 1 of 2
CONFIDENTIAL

Please Print Clearly:

Student's Name: _____ Gender (M or F): _____

Date of Birth: _____

Address:

City: _____ State: _____ Zip Code: _____

Parent/Guardian Contact Information

Mother/Female Guardian's Name:

Address:

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell/Work #: _____

Father/Male Guardian's Name:

Address:

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell/Work #: _____

Emergency Contact Information

In case of emergency and parent/guardian cannot be reached, contact:

1) _____ Phone #: _____

2) _____ Phone #: _____

Health History (check all that apply)

_____ Asthma _____ Ear Infections _____ Heart Disease

_____ Diabetes _____ Epilepsy _____ Other

Please provide further specific information that may be helpful:

Allergies (check all that apply)

Animal Insect Stings Pollen
 Food Medicine/Drugs Other

Please provide further specific information that may be helpful:

MBHS Health History - Page 2 of 2

Other Health Conditions (check all that apply)

Emotional Disturbance Fainting Hearing Impairment
 Special Diet Motion Sickness Wears Contacts
 Wears Glasses Nosebleeds Other

Please provide further specific information that may be helpful:

Immunizations (please give dates of last immunization)

Tetanus: _____ MMR: _____ Hepatitis B: _____

Is your child under the care of a physician?

Yes No

Does your child have a condition requiring regular medication?

Yes No

Is there any restriction on your child's activities?

Yes No

If you answered "yes" to any of the above questions, please provide specific information that may be helpful:

I am the parent/guardian of _____. Should a medical emergency arise during my child's participation in a MBHS Band activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers listed below. If it is believed that my child's life or health may be adversely affected by the delay that an attempt to contact me or my alternate would cause, I consent to:

1) The administration of medical treatment and/or surgical procedures deemed necessary

by the medical doctor and/or the medical facility identified below or chosen by the adult

in charge; and
2) The immediate administration of life-saving measures deemed necessary under the circumstances.

Insurance Information

Insurance Company: _____

Group Number: _____

Policy Number: _____ Policy Holder's Name: _____

If I cannot be reached in the event of an emergency, the following person is authorized to act in my behalf:

Designated Alternate:

Relationship to Student: _____ Phone(s): _____

Preferred Medical Doctor/Medical Facility:

Doctor's Phone Number: _____

Signature of Parent/Guardian

Date