

DMEA ALL-STATE STUDENT MEDICAL INFORMATION

Please complete and return this form to your All-State ensemble chair at the first rehearsal. Information will be kept confidential and used only in case of emergency. Complete separate forms for each All-State ensemble.

Student's name: _____ Home telephone: _____

Daytime telephone: _____ Emergency telephone: _____

Medical care insurer and account number: _____

Telephone number of medical care insurer: _____

Doctor's name and telephone number: _____

Does the above named student:

Has the above named student:

1. Suffer from asthma? _____

1. Been hospitalized recently? _____

2. Have diabetes? _____

2. Currently been placed under doctor's care? _____

3. Have a heart condition? _____

3. Sustained injuries that presently require medical

4. Have any known allergies? _____

attention? _____

5. Have a history of seizures? _____

4. Had or have fainting spells? _____

If you answered "yes" to any of the above questions, please attach a separate sheet that gives details and any other pertinent information that will assist us to assure that your child will be healthy and comfortable.

Check if child receives no medications

I give permission for my child to be administered the following medications (administered by school nurse):

Name of medication: _____ Dose (amount to be taken): _____

Time(s) to be taken: _____ How is it taken? _____

NOTE: ALL MEDICATION MUST BE PRESENTED IN ITS ORIGINAL CONTAINER

Name and telephone number of doctor who prescribed medication(s): _____

My permission is granted for DMEA to make appropriate contacts with school nurses, doctors, and hospitals on behalf of my child in the event of an emergency (signature required below):

Every effort will be made to contact parents in the event of an emergency.