

DMEA ALL-STATE ORCHESTRA MEDICAL FORM

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 licensed 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 the staff of All-State Orchestra to make appropriate contacts with 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.