

## 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.