

Booker T. Washington High School Band EMERGENCY DATA

STUDENT INFORMATION:

Last Name _____ First _____ Middle _____ Nickname _____

Address _____ Zip Code _____

DOB _____ Age _____ Grade _____ Home Phone _____ Cell _____

Female Guardian _____ Relationship _____

Employer _____

Work Phone _____ Cell _____ Other Emergency Phone _____

Male Guardian _____ Relationship _____

Employer _____

Work Phone _____ Cell _____ Other Emergency Phone _____

Insurance Company _____ Policy No. _____

Doctor _____ Hospital _____

Emergency Contacts:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

MEDICAL INFORMATION

List ALL current medications and reason for each, including OTC (Over the Counter) meds:

Allergies to Food (write N/A if not applicable):

Allergies to Insects? YES NO Bees? YES NO Epi Pen? YES NO

Medical Condition	Current	Past	None	Medical Condition	Current	Past	None	Medical Condition	Current	Past	None
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____			

Allergies to Medications (write N/A if not applicable): _____

Has your child had a tetanus shot within the last six years? YES NO List any other conditions or factors which your child is known to have:

Booker T. Washington High School Band
PERMISSION FORM

_____ has my permission to participate
BAND STUDENT LEGAL NAME
in all band activities. I understand that most of these activities take place in Escambia County.
However, I also understand that some activities may take place outside the county, and some may take
place outside the State of Florida.

The Health History I have provided is accurate to the best of my knowledge.

PRINT NAME OF LEGAL GUARDIAN

SIGNATURE OF LEGAL GUARDIAN

DATE

THIS FORM MUST BE NOTARIZED BY A NOTARY PUBLIC

Sworn and subscribed before me _____, a Notary Public
in the State of Florida, County of Escambia, this _____ day of _____
in the year _____ .

_____ is personally known _____
and/or provided identification in the form of _____ .

(Seal) _____ Notary Public State of Florida