CLAIRTON MARCHING BAND
Clairton Education Center
501 Waddell Ave. Clairton, PA 15025
David Geckle - Director

PERSONAL HEALTH HISTORY

To be filled out by parent or guardian. PLEASE PRINT IN INK.

Name of Band Member _____. D.O.B._____Age_____

Name of Parent/Guardian_____Home Phone # _____

Home Address_____Work Phone #_____

City_____State_____ Zip _____

CHECK ALL ITEMS THAT APPLY, PAST OR PRESENT TO YOUR HEALTH HISTORY.
PLEASE EXPLAIN ANY YES ANSWER.

GENERAL INFORMATION

Asthma	____YES	____NO	Convulsions/Seizures	_____YES	_____NO
Heart Trouble	YES	NO	High Blood Pressure	YES	NO
Diabetes	YES	NO	Cancer/Leukemia	YES	NO
Hemophilia	YES	NO	Kidney Disease	YES	NO

Allergies: Food, Medicines, Insects or Plants ____YES ____NO
EXPLANATION:

_____

List any medications to be taken and times

_____

List any physical or behavioral conditions that may affect or limit full participation:

_____

_____

DATE OF LAST TETANUS SHOT: _____

Name of Personal Physician: _____

Personal Health/Accident Insurance carrier: _____
Policy Number: _____

PARENTAL AUTHORIZATION:
This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activity, except as noted. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgment of medical person dictates.

Signature _____Date _____
Parent/Guardian

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PARENTAL AUTHORIZATION FOR TREATMENT

I/We _____
(Name of Parents/Guardian)
Of _____
(Address)

Parents/Guardian of _____, do hereby grant permission to
(Name of Student)
Mr. Geckle and/or the Honeybear coordinator and the Clairton Education Center to authorize to perform medical, surgical or emergency treatment at the closest facility and in the best interest of my/our child, who was born on _____.

This authorization is given with the understanding that the Custodian or Temporary Guardian will act in place of our absence, the parents/guardians, during the period of time that the child is with the band at an event, from July 2019-July 2020. This authorization is granted for the benefit of my/our child above named, and the Grantors of this authorization will hold the Custodian or Temporary Guardian harmless for any and all medical or hospital treatment resulting from the use of this authorization. I/We, the undersigned, authorize the Custodian of Temporary Guardian, above named, to give such information concerning me/us, the parents/guardians, as may be necessary for proper treatment of my/our child.

PARENTAL AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION

I hereby authorize the Clairton Band Boosters to administer non-prescription medication as needed to my/our child during any band activities.

This authorization is granted for the benefit of my/our child and the grantors of this authorization will hold Mr. Geckle, the Honeybear Director and/or the Clairton Band Boosters harmless for any results from the use of this authorization.

PLEASE INDICATE (BY INITIALING) WHICH TYPE OF MEDICATION YOU WISH YOUR CHILD TO RECEIVE:

_____ TYLENOL (ACETAMINOPHEN)

_____ ADVIL (IBUPROFEN)

_____ DRAMAMINE

_____ BENADRYL

Parents/Guardians Signature_____Date _____