

**CREEKVIEW HIGH SCHOOL BAND**  
**STUDENT HEALTH INFORMATION**

STUDENT NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_  
PHYSICIAN'S NAME \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

HEALTH HISTORY-CIRCLE ALL THAT APPLY

ALLERGIES

IF YES, PLEASE LIST ALLERGEN (INSECTS, FOOD, MEDICATION) REACTION, AND TREATMENT. \_\_\_\_\_

SEASONAL ALLERGIES (HAY FEVER)

ASTHMA

SEVERE HEADACHES

DIABETES

SEIZURES

HEART CONDITION

OTHER \_\_\_\_\_

PLEASE LIST ANY MEDICATIONS TAKEN AND REASON \_\_\_\_\_

PLEASE LIST ANY OTHER HEALTH CONCERNS AND/OR RESTRICTIONS \_\_\_\_\_

I, \_\_\_\_\_, GIVE PERMISSION FOR THE CREEKVIEW HS BAND PERSONNEL TO ADMINISTER THE INDICATED MEDICATIONS ACCORDING TO PACKAGE DIRECTIONS TO MY CHILD, \_\_\_\_\_, ON AN AS NEEDED BASIS. CHECK EACH MEDICATION YOU AUTHORIZE TO BE GIVEN AS NEEDED.

TYLENOL \_\_\_\_\_ CALAMINE LOTION \_\_\_\_\_ PEPTO BISMOL \_\_\_\_\_  
ADVIL \_\_\_\_\_ BENADRYL \_\_\_\_\_ SUNCREEN \_\_\_\_\_

IN CASE OF SERIOUS ILLNESS/INJURY, THE CREEKVIEW HS BAND PERSONNEL WILL TELEPHONE EMERGENCY MEDICAL SERVICES (911) FOR IMMEDIATE TRANSPORTATION TO THE CLOSEST HOSPITAL. I, THE PARENT/LEGAL GUARDIAN, AUTHORIZE THE TRANSPORT OF AND TREATMENT BY THE HOSPITAL EMERGENCY STAFF FOR MY CHILD, \_\_\_\_\_.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE