

Singing School Medical Form

This completed form must be brought to registration by all Students who are under 18 and unaccompanied by parents.
Please save the blank form to your computer and then complete.

Name: _____ SS # _____ - ____ - ____ DOB ____/____/____ Age ____
Last First MI M D Y

Address: _____ Phone: (____) _____
Number and Street City/State/Zip AC

Name of Parent/Legal Guardian: _____ SS # _____ - ____ - ____

Address: _____
Number and Street City/State/Zip

Phone: Home (____) _____ Business (____) _____ Cell (____) _____
AC AC AC

Family Physician's Name: _____

Address: _____ Phone: (____) _____
Number and Street City/State/Zip AC

Parent's address during the School if different from home address: _____

Phone: (____) _____

Hospital/Medical Insurance, give name and identification number: _____

(You may attach a copy of your medical health insurance card if available.)

If you are coming with an adult who is responsible for you, but who is NOT your parent or legal guardian, please give the name: _____

Name of two relatives/friends who may be contacted in case you cannot be reached in an emergency:

1. Name: _____ Address: _____ Phone: (____) _____

2. Name: _____ Address: _____ Phone: (____) _____

GENERAL HEALTH AND MEDICAL HISTORY:

1. Specify any chronic or long-term illness: _____

2. Specify any operations or serious injuries: _____

3. Check communicable diseases? Measles ___ German Measles ___ Mumps ___ Chicken Pox ___ Other: _____

4. Name any known allergy: Drugs _____ Food _____
Animals _____ Plants _____ Other _____

Explain reaction and indicate medication used. _____

5. Check any of the following: Sleepwalking ___ Other sleep disturbances ___ Nightmares. ___ Fainting ___
Convulsions ___ Stomach upsets ___ Constipation ___ Emotional problems ___ Asthma ___ Give details: _____

6. Immunizations? DPT ___ German measles ___ Measles ___ Mumps ___ Polio ___ Other _____

7. MEDICATION: Is he/she bringing medication to school? ___ If yes, give name of medication: _____

(Note: Directions for administering must be on the label, name of medication, student's name)

8. RESTRICTIONS: Any activity restrictions? ___ If yes, specify: _____

In the event I cannot be reached in an emergency, I hereby give permission for the physicians selected by the officials of the school to provide whatever medical or surgical treatment is necessary.

Date _____ Signed _____ Parent ___ Legal Guardian ___ (Check One)

Parent/legal guardian should complete the following within 48 hours before student's arrival at school.

I certify that, to the best of my knowledge, my child has not been exposed to any communicable disease within the past three weeks.

Any known or obvious change in health status? No ___ Yes ___ If yes, explain: _____

Date _____ Signed _____ Parent ___ Legal Guardian ___ (Check One)