



Pride Of The West

West Forsyth High School Bands

4155 Drew Road
Cumming, GA 30040
(770) 888-3470

West Forsyth Band Boosters,

Medical Form 2011-2012

Student Contact Information:

Full Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Contact Information:

Mother/Guardian Full Name: _____

Home Phone: _____ Cell Phone: _____

Father/Guardian Full Name: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Information: PLEASE LIST SOMEONE OTHER THAN PARENTS (LOCAL CONTACT ONLY, PLEASE)

Emergency contact name: _____ Phone Number: _____

Relationship to student: (relative, neighbor, friend, etc.): _____

Student Medical Information: MUST BE COMPLETE BEFORE STUDENT MAY PARTICIPATE IN BAND CAMP

Physician: _____ Telephone Number: _____

Date of last Tetanus Shot: ____ / ____ / ____

Does student have any known allergies? Yes ____ No ____ If so list: _____

Student is authorized to carry the following medications: _____

Place an X if the student may be given: Advil ____ Tylenol ____ Sudafed ____ Benadryl ____ Other: _____

Place an X by any of the following that may apply to your child: Heart Disease ____ High Blood Pressure ____

Diabetes ____ Asthma ____ Seizures ____ Bronchitis ____ Diabetes ____ Contacts/Glasses ____ Braces ____

Any other information concerning your child's medical conditions may be explained on the reverse side of this form.

***Students are **REQUIRED** to carry health insurance of some kind. If family or employer insurance is not available, students may carry 24 hour school insurance. Students without insurance must provide a signed and notarized waiver letter from parents.

Insurance Information:

Health Insurance Company: _____

Name of Policy Holder: _____

Group Number: _____ ID/Member Number: _____

I hereby authorize authorized designees of the WFHS Band Program to seek medical attention for my child listed above.

Signed _____ Date: ____ / ____ / 2011

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM AS WELL

Additional First Aid Treatment Consent

STUDENT's NAME _____

The volunteers running the first aid stations need permission to administer over the counter medications for the following conditions.

Note: Every attempt will be made to provide sugar free medications for students with diabetic conditions.

Heat related stress: Electrolytes – sport drink powders, salt tablets in extreme circumstances, Solarcaine spray and gel for sunburn, sunscreen.

Muscle Strains: Ben gay, Icy Hot, topical analgesics such as Aspercream

Digestive tract problems: Nausea (cannot be used with diabetics), Antacid tablets (check for interaction with your child's prescription drugs), Imodium – loperamide hydrochloride, Gas relief tablets

Insect bite/sting reactions: Benzocaine spray – sting kill, Benadryl, topical hydrocortisone, insect repellent

Rashes: Topical hydrocortisone, topical calamine lotion

Wound infection (existing and preventative): Topical antibiotics such as triple antibiotic ointment and Bacitracin

Foreign objects in the eye: Eye flush aids, Visine

Sore throat/cold: Throat spray, Chloraseptic lozenges, Tylenol

If you do **NOT** wish to have any of these medications administered to your child, please indicate which ones below:

Other Medical Information you think we should be aware of: _____

Parent/Guardian Full Name: _____

Parent/Guardian Signature: _____

Date: ____ / ____ / 2011