Blue Ridge Corps of Cadets
Medical Form

Name of Student____Date of Birth__________________

Street Address____SS#__________________

Health History (Please give dates where known)

Surgery or Hospitalizations (within last year)____

Behavioral Problems___________________Diabetes_____________________Seizures_______________

Allergies (pollen, dust, medications, insect stings, food, etc.)_______________________________________

Tetanus (last injection)____

Any other special health conditions____

Is Student under medical treatment at this time? Yes__ No___ Reason, if yes________________________

Listed below are medications that are to be given while away from school on a band activity (All medications must be provided in the original container)

Medication	Dosage	Time To Be Given	Medical Condition

1.____

2.____

3.____

(Check one) Parent sending medication_____ , or Medication to be sent from health room________

I understand that, if my son/daughter becomes ill or is injured while with the band at practice or on a trip away from school, the chaperones will attempt to contact me or an emergency contact at the numbers listed below.

Parent/Guardian Name(s)_____________________________________Home Phone__________________

Mothers Work Phone____________Fathers Work Phone____________Cell Phone____________________

Alternate Contact Name_______________________________________Relationship__________________

Alternates Home Phone_________________Work Phone___________Cell Phone____________________

Family Doctor____Office Phone_________________

Insurance Company____

Policy Holders Name____

ID Number / Group Number____

Any other insurance information we need in order to help your child________________________________
____

I give permission for my son/daughter to be given treatment by a licensed physician and/or hospital for any medical or surgical emergency and I agree that I will be solely responsible for any and all costs incurred as a result. I further agree to identify and hold harmless the School District, its Board of Trustees and its employees for any injury that occurs to my child which is not the result of action or inaction by the District or its representatives.

Parent/Guardian Signature____Date__________________

I give my permission for the principal or his/her designee to assist my child with the above medications or the following medications if necessary. The medications listed below were approved by Dr. Ben Taylor, Inman, SC.

1. Tylenol for pain _______Yes _______No
2. Doonagel for diarrhea _______Yes _______No
3. Dramamine for nausea _______Yes _______No
4. Benadryl for allergies _______Yes _______No
5. Polysporin for cuts _______Yes _______No

Parent/Guardian Signature____Date__________________

I understand that I need to contact the director in writing if any additions or deletions need to be made to the medical form.

Parent/Guardian Signature____Date__________________

COPY OF INSURANCE CARD (Front and Back)