MEDICAL TREATMENT FORM

PORTSMOUTH HIGH SCHOOL MUSIC DEPARTMENT
120 Education Ln, Portsmouth, RI 02871
1-401-683-2124

Last Name: ________________________ Student Cell# ________________________

Chaperone Name:____________________________________

Please be sure to fill out ALL information on the form, if it does not apply, please write N/A

______________________________ Student Name

______________________________ Date of Birth

M F Sex

______________________________ Parent's / Guardian's Name

______________________ Home Phone

______________________ Cell Phone (parent/Guardian)

______________________________ Address

______________________________ City, State, Zip

1. If a parent is not available in the unlikely case of an emergency, please notify: (please give two names other than parents)

______________________________ Primary Emergency Contact

______________________________ Secondary Emergency Contact

________________ Relationship ________________ Phone

________________ Relationship ________________ Phone

2. Physician's Name:____ Phone:______________________________

***** PLEASE USE THE REVERSE SIDE OF THIS FORM TO LIST MEDICATIONS *****

3. Does your son/daughter have any **illness** that he/she is being treated for? (Ex. Diabetes, epilepsy, asthma) Yes________ No________

   If yes, indicate illness: ____
   (All information given is confidential)
   If asthmatic, does your son/daughter use an inhaler? Yes________ No________ If yes, name of inhaler: __________________

4. Please indicate if your son or daughter is allergic to the following: (yes or No)

   Ibuprofen (Advil) ________ Penicillin________ Aspirin________ Other Drugs________

   Bee stings________ Food Allergy________
   If yes, please describe the type of **reaction**, (Hives, breathing difficulties, swelling, etc)

5. If it is felt that your son/daughter should have the medication listed here, may an official chaperone administer your son/daughter the medicine? (Yes or No)

   Cough Syrup________ Cold/Allergy pill________ Tylenol________ Advil________ Something for upset stomach________

   Dramamine_________ Other (please indicate preference) ____

6. Date of last tetanus shot: ____________________________

7. Please indicate health insurance information:

   Plan: ____ (If Blue Cross/Blue Shield, indicate MA or RI)

   ID Number____________________________________ Subscriber's Name: ________________________________

8. Suggestions from parents as to limitations or signs of health risks for chaperones to be aware of:

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AUTHORIZATION: This Health History is correct insofar as I know and the student therein described has my permission, as legal/guardian, to engage in all prescribed activities, except as noted by me in the space provided above. In the event that I or the individuals listed above for emergency notification cannot be reached in an "emergency," I hereby give my permission to the physician selected by Mr. Rausch to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my son/daughter as named above.

Parent/Guardian Signature:____ Date:______________________________

Portsmouth High School Student Medication Identification

Student Name:____ Student Cell#______________________________________

Please list any medications your son/daughter takes on a regular basis **(Please be sure to send it with them)**. Indicate below the name of medication and the specific times of day to be taken:

Medication Name and Dosage	When To Take	Comments