

MCHS BAND & GUARD HEALTH INFORMATION

Student Name

Last _____ First _____ Middle _____
 Address _____
 City/State _____ Zip _____
 SSN _____ Grad Year _____
 DOB _____ Age _____

Parent/Guardian Name _____
 Address _____
 City/State _____ Zip _____
 Phone #1 _____ Home Work Cell
 Phone #2 _____ Home Work Cell
 Email _____

Parent/Guardian Name _____
 Address _____
 City/State _____ Zip _____
 Phone #1 _____ Home Work Cell
 Phone #2 _____ Home Work Cell
 Email _____

Family Doctor _____
 Phone _____
 Health Insurance Information
 Company _____
 Person Covered _____
 Group # _____
 ID# _____

PLEASE ATTACH COPY OF FRONT & BACK OF INSURANCE CARD(S)

Student takes medications Yes No
 Student manages own medications
 Student needs assistance managing medications

Medication Name	Dosage
_____	_____
_____	_____
_____	_____

Please check if problems exist with any of the following:

<input type="radio"/> Lungs	<input type="radio"/> Mouth/Throat	<input type="radio"/> Fatigue
<input type="radio"/> Heart	<input type="radio"/> Neck	<input type="radio"/> Genital
<input type="radio"/> Urinary/Bowel	<input type="radio"/> Abdomen	<input type="radio"/> Mental/Emotional
<input type="radio"/> Skin	<input type="radio"/> Shoulders/Arms	<input type="radio"/> Nutrition/Weight Control
<input type="radio"/> Head	<input type="radio"/> Hands	<input type="radio"/> Other
<input type="radio"/> Ears	<input type="radio"/> Hips, Legs, Feet	_____
<input type="radio"/> Eyes	<input type="radio"/> Back	_____
<input type="radio"/> Nose	<input type="radio"/> Muscles	_____

Medical History

Yes	No	Medical History	Explanation
<input type="radio"/>	<input type="radio"/>	Any on-going medical problem	_____
<input type="radio"/>	<input type="radio"/>	Asthma	_____
<input type="radio"/>	<input type="radio"/>	Allergic to medicine, foods, insect stings	_____
<input type="radio"/>	<input type="radio"/>	Wear glasses or contact lenses	_____
<input type="radio"/>	<input type="radio"/>	Braces, bridges, chipped teeth	_____
<input type="radio"/>	<input type="radio"/>	Past surgical procedures	_____
<input type="radio"/>	<input type="radio"/>	Past hospitalizations	_____
<input type="radio"/>	<input type="radio"/>	Known deformities	_____
<input type="radio"/>	<input type="radio"/>	Ever been dizzy	_____
<input type="radio"/>	<input type="radio"/>	Ever had chest pain	_____
<input type="radio"/>	<input type="radio"/>	Ever had a racing heart	_____
<input type="radio"/>	<input type="radio"/>	Ever passed out	_____
<input type="radio"/>	<input type="radio"/>	High blood pressure	_____
<input type="radio"/>	<input type="radio"/>	Heart murmur	_____
<input type="radio"/>	<input type="radio"/>	Family member die of heart problem before age 50	_____
<input type="radio"/>	<input type="radio"/>	Denied or restricted participation in sports for heart problem	_____
<input type="radio"/>	<input type="radio"/>	Myocarditis or mononucleosis within past month	_____
<input type="radio"/>	<input type="radio"/>	Head injury or concussion	_____
<input type="radio"/>	<input type="radio"/>	History of seizures	_____
<input type="radio"/>	<input type="radio"/>	Frequent or severe headaches or migraines	_____
<input type="radio"/>	<input type="radio"/>	Numbness or tingling in arms, hands, legs, feet	_____
<input type="radio"/>	<input type="radio"/>	Ever had stinger, burner or pinched nerve	_____

Date of most recent tetanus shot _____

Additional comments or explanations

I certify that all information is correct to the best of my knowledge.

Student signature _____ Date _____

Parent/Guardian signature _____ Date _____

Both Student and Parent/Guardian signatures are mandatory.

All information is kept confidential.