BRAINERD CHOIR
HIGH SCHOOL

STUDENT MEDICAL INFORMATION

STUDENT'S NAME_____
ADDRESS_____**CITY**_____
DATE OF BIRTH_____**HOME TELEPHONE** ____-_____-_____
PARENT'S WORK TELEPHONE_____
PARENT'S NAME_____
PARENT'S/GUARDIAN'S PLACE OF EMPLOYMENT_____
INSURANCE COMPANY_____**POLICY NUMBER**_____

If parent or guardian cannot be reached call this person_____
Their Telephone Number_____

ANY MEDICATION(S) STUDENT IS CURRENTLY TAKING AND DOSAGE:
_____
REASON:_____
ALLERGIES: (Check)__Aspirin ___Penicillin ___Sulfa ___Insect Stings
___Tetracycline ___Food (Specify)_____
Other (Specify)_____

HEALTH HISTORY: (CHECK)___Diabetes ___Orthopedic Problems ___Asthma
___Epilepsy ___Cardiac Problems
(Specify)_____
DO WE HAVE PERMISSION TO ADMINISTER TO THE STUDENT:
(Check)___Aspirin ___Acetaminophen (Tylenol) ___ Ibuprofen

DATE OF LAST TETANUS SHOT:_____

I give permission to the physician or hospital to secure proper treatment for and to order medications, injections, anesthesia, or surgery for the student as named above. If an emergency arises, I understand it might be necessary for my son/daughter to receive medical care before I can be contacted.

(Parent signature)_____**Date**_____
Home Phone _____
Work Phone _____
Cell Phone _____