Health Form

Physical Examination: Completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant, or certified advanced registered nurse practitioner

Student'sName:_____Date of Birth: ___/___/____
Height: _____ Weight:_____ % Body Fat: _____ Pulse: _____ Blood Pressure: ____ / ____
(____/____ , ____ /____) Temperature: _____Hearing: right: P _____ F _____ left: P _____ F _____
Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes / No Pupils: Equal / Unequal

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL:			
1. Appearance			
2. Eyes/Ears/Nose/			
3. Lymph Nodes			
4. Heart			
5. Pulses			
6. Lungs			
7. Abdomen			
8. Skin			
MUSCULOSKELETAL:			
10. Neck			
11. Back			
12. Shoulder/Arm			
13. Elbow/Forearm			
14. Wrist/Hand			
15. Hip/Thigh			
16. Knee			
17. Leg/Ankle			
18. Foot			

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER: I hereby certify that each examination listed above was performed by me or an individual under my direct supervision with the following conclusion(s): ____ Cleared without limitation
____ Disability:_____ Diagnosis: _____
Precautions:_____
_____
Not cleared for:_____Reason:_____
Cleared after completing evaluation/rehabilitation for: _____
Referred to: _____For:_____
Recommendations:_____
_____

Name of Physician
(print):_____Address:_____Date:_____
_____ Physician/Physician Assistant/
Nurse Practitioner (Signature)

Medical Release: Completed by parent Student Name: _____

InsuranceProvider:_____Policy#_____Group#_____

Physician Name:_____ Phone #: _____

Check all that apply:		Details:
☐	Asthma	Inhaler? Y / N
☐	Allergies	Epi-pen? Y / N
☐	Diabetes	
☐	Heart Condition	
☐	Migraines	
☐	Seizures	
☐	Other	

I authorize the use of the following over-the-counter medicines by my child during band camp, rehearsals, performances, and/or competitions should it be deemed necessary:		
☐	Acetaminophen –Tylenol	Headaches, muscle pain
☐	Antibiotics (topical) – Neosporin	Scrapes, cuts
☐	Benadryl (oral)	Allergies
☐	Benadryl (topical)	Bug bites, rash
☐	Ibuprofen –Advil, Motrin	Headaches, muscle pain
☐	Intestinal Medications – Pepto,	Upset stomach

Please list all prescription and non-prescription medication(s) that is taken on a regular basis:

_____

_____

In the event that parents/guardians are not available, I designate the following person as an **Emergency Medical Contact**:

Name: _____Phone:_____

In the event that parents/guardians and the Emergency Medical Contact cannot be reached, I authorize the Director of Bands and any designated chaperones to obtain, through any licensed medical personnel/physician of their own choosing, any medical care that they deem reasonably necessary should my child be injured or become seriously ill during any and all functions. I hereby grant permission to licensed hospital and/or health center staff members to administer immediate medical treatment as deemed necessary. Further, I understand that I am responsible for payment of expenses incurred relating to my child's medical treatment. I agree to keep all medical information previously provided about my student up to date. **Signature(s):**

Parent 1: _____ Date: _____