

2009-2010 GREENSBORO SYMPHONY YOUTH ORCHESTRA HEALTH FORM

<u>NAME (Last, First, Middle):</u>			<u>Parent/Guardian:</u>			<u>Phone # Home:</u>		
						Cell:		
<u>Address</u>		<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Birth date:</u>	<u>Age:</u>	<u>Sex:</u>	
<u>Emergency Contact:</u>						<u>Phone# Home:</u>		
						Cell:		
<u>Insurance Information:</u>								
<u>Name of Company:</u>			<u>Address and Phone#:</u>			<u>Policy Number:</u>		
<u>Health History:</u> (check all that apply)								
<u>Allergies/Intolerances:</u>			<u>Chronic/Recurring Illnesses:</u>			<u>Recent illness or injury:</u>		
<input type="checkbox"/> Food: _____ <input type="checkbox"/> Environmental: _____ <input type="checkbox"/> Drug: _____ <input type="checkbox"/> Headaches _____			<input type="checkbox"/> Asthma _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Epilepsy/Seizures _____ <input type="checkbox"/> Other _____			_____ _____ _____		
<u>Special medical or dietary regimen to be followed:</u> (please specify) _____								
Comment where applicable:								
<input type="checkbox"/> Fainting _____ <input type="checkbox"/> Motion Sickness _____ <input type="checkbox"/> Nosebleeds _____ <input type="checkbox"/> Contacts _____ <input type="checkbox"/> Glasses _____ <input type="checkbox"/> Sleep Disturbances _____ <input type="checkbox"/> Other _____								
<u>Over the Counter Medications:</u> my child has permission to take or use the following medications:								
<input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Pepto Bismol <input type="checkbox"/> Ibuprofen/Advil/Motrin <input type="checkbox"/> TUMS/antacid <input type="checkbox"/> Sudafed/Decongestant <input type="checkbox"/> Benadryl/Antihistamine <input type="checkbox"/> Robitussin/Expectorant <input type="checkbox"/> Natural Tears/Eye Drops								
<u>Record of Immunizations:</u> D.T.P. (Diphtheria, Tetanus, Pertussis) _____ year of last booster <u>Oral Polio</u> _____ year of last booster								
						<u>MMR (Measles, Mumps, Rubella)</u> _____ year of last booster <u>Hepatitis B</u> _____ year series completed		
<u>Name of Physician:</u> _____			<u>Phone#:</u> _____			<u>Date of Last Physical Exam:</u> _____		
<u>Daily Medications:</u> (Medications must be clearly labeled and in their original containers. Please indicate (circle) who will administer medications: student or lead chaperone. For most students, taking their own medications is the best choice.) Use back of page if necessary.								
<u>MEDICATION</u>		<u>DOSE</u>		<u>FREQUENCY</u>		<u>COMMENTS</u>		
1.								
2.								
3.								
<u>Parents of GSYO Student Musicians:</u> I hereby authorize any medical treatment, including dispensing of over the counter medications, as indicated above, for my son or daughter which may be recommended by a licensed health care provider. The GSYO has my permission to transport my son or daughter to a hospital or doctor for medical treatment should there be an illness or injury.								
<u>SIGNATURE OF PARENT OR GUARDIAN:</u> _____						<u>DATE:</u> _____		