



Permit for Treatment

Emergency Procedure/Health Information

(Please Print)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (H)(\_\_\_\_\_) \_\_\_\_\_ D.O.B.\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_\_) \_\_\_\_\_

Emergency Contact #1 Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_\_) \_\_\_\_\_

Emergency Contact #2 Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_ (C)(\_\_\_\_\_) \_\_\_\_\_

Date of last Tetanus Booster\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ May your child swim? YES NO

Please list any health information that requires your child to have limitations in his or her activity? (If yes, please explain in the space below.)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Is your child presently on any medication? YES NO (If yes, please list medication(s), dosage, and time of administration.)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

\*\*No student will be allowed to administer his/her own medications while on a trip.

\*\*All medications must be in a container with the original pharmacy label and accompanied by the required HCPSS medication form. These forms will be made available prior to any field trips.

Describe any significant medical condition about which we should be aware!

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_



# River Hill High School-Department of Music

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Does your son/daughter have? (If yes, please explain)

- YES  NO Allergies \_\_\_\_\_
- YES  NO Heart Condition \_\_\_\_\_
- YES  NO Diabetes \_\_\_\_\_
- YES  NO Asthma \_\_\_\_\_
- YES  NO Seizures \_\_\_\_\_
- YES  NO Dietary Restrictions \_\_\_\_\_
- YES  NO Other \_\_\_\_\_

Is your son/daughter subject to? (If yes, please explain)

- YES  NO Fainting \_\_\_\_\_
- YES  NO Sleep Walking \_\_\_\_\_
- YES  NO Upset Stomach \_\_\_\_\_
- YES  NO Other \_\_\_\_\_

Does your son/daughter react to? (If yes, please explain)

- YES  NO Bee Sting \_\_\_\_\_
- YES  NO Penicillin \_\_\_\_\_
- YES  NO Other Drugs \_\_\_\_\_
- YES  NO Poison Ivy, Oak, Sumac \_\_\_\_\_
- YES  NO Food \_\_\_\_\_
- YES  NO Other \_\_\_\_\_

Please answer the following. (If yes, please explain)

- YES  NO Did your son/daughter have a serious illness in the last year? Illness? \_\_\_\_\_
- YES  NO Did your son/daughter have surgery within the last year? Type of Surgery? \_\_\_\_\_
- YES  NO Does your son/daughter have any sight or hearing impairment? Type? \_\_\_\_\_
- YES  NO Does your son/daughter wear contact lenses? \_\_\_\_\_

I give my permission to administer the following over the counter medications.

Tylenol  Ibuprofen  Other: (specify) \_\_\_\_\_

This health history is correct to the best of my knowledge and the student herein described has permission to engage in all activities unless otherwise indicated. In the event of an accident or illness, I give my permission to the physician or hospital selected by a representative of my son/daughter's school to hospitalize, secure proper treatment for, order medications, injections, anesthesia, or surgery for my child as named above **in case of emergency** while he/she is in the care of the RHHS Music Program. I understand that I will be notified as soon as possible. I/We agree not to hold Howard County Public Schools and/or River Hill High School administration, faculty or any staff member liable.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_