# KHHS Band Medical History Report

**IMPORTANT:** This form must be completed in full and signed by both participant and parent before participation will be allowed. A doctor's signature is not required.

**A MESSAGE TO YOU CONCERNING YOUR HEALTH:**

It is the aim for each student to enjoy a complete band experience within his/her physical and mental ability. Your medical history will provide the essential information needed to meet this goal. The history is required primarily to determine what adjustments, if any, must be made in schedules of activities to accommodate individual needs. This form will be kept on file by the KHHS Band staff to be used in the event of injury or illness or planning for band participation.

Participation in the band program is at the sole discretion and judgment of the participants and at his/her own risk. The participant and the participant's parent/guardian assume full responsibility for any injuries or damage that may occur. The participant and the participant's parent/guardian hereby release and agree to hold harmless Kenowa Hills, its Board Members, Staff, Faculty and Instrumental Music Boosters from all claims, actions, damages, and liabilities for personal injury or damage relating to or arising from any activity except where the injury is cause by negligence of the school, its agents or employees.

| Last Name, First Name (Please Print) | | Date of Birth |
|---|---|---|
| Home Street Address | | Age |
| Home City, State, Zip | | Home Telephone Number |
| **In Case of Emergency Contact:** | | |
| Last Name, First Name (Please Print) | Relationship | Home Telephone Number |
| Street Address | Business Address | |
| City, State, Zip | City | Business Telephone Number |

( ) Scarlet Fever
( ) Measles
( ) German Measles
( ) Mumps
( ) Chicken Pox
( ) Malaria

( ) Gum or Tooth Problems
( ) Sinusitis
( ) Eye Problems
  ( ) Glasses
  ( ) Contacts

( ) Ear, Nose, Throat Problems
( ) Sickle Cell Anemia
( ) Pneumonia
( ) Diabetes
( ) Pleurisy
( ) Hypoglycemia
( ) Trick Knee, Shoulder, Etc.
( ) Immune System Disorder
( ) Kidney Disease

( ) Cancer
( ) Seizures
( ) Epilepsy
( ) Recent Weight Gain/Loss
( ) Insomnia
( ) Frequent Anxiety

( ) Frequent Depression
( ) Worry/Nervousness
( ) Recurrent Headaches
( ) Recurrent Colds
( ) Head Injury w/ Unconsciousness

( ) Hay Fever
( ) Asthma
( ) Tuberculosis
( ) Shortness of Breath
( ) Allergies
  ( ) Penicillin
  ( ) Sulfa
  ( ) Serum
  ( ) Foods
  ( ) Other
  _____

( ) Protein/Sugar in Urine
( ) Jaundice/Liver Problems
( ) Stomach/Intestinal Problems
( ) Dizziness/Fainting
( ) Pain/Pressure in Chest
( ) Chronic Cough

( ) Palpitations
( ) High/Low Blood Pressure
( ) Rheumatic Fever
( ) Heart Murmur
( ) Heart Problem/Disease

( ) Joint Disease/Injury
( ) Arthritis
( ) Ankle Sprain/Knee Injury
  ( ) Mild ( ) Mild
  ( ) Severe ( ) Severe
( ) Cholesterol Problem
( ) Back Problem
( ) Sexually Transmitted Disease

( ) Surgery
  ( ) Appendectomy
  ( ) Tonsillectomy
  ( ) Hernia Repair
  ( ) Other _____
( ) Gallbladder Problem/Gallstones
( ) Recurrent Diarrhea
( ) Ruptured Hernia
( ) Weakness/Paralysis
( ) Frequent Urination

Females Only:

( ) Irregular Periods
( ) Severe Cramps
( ) Excessive Flow
( ) Other _____

# KHHS Band Medical History Report

PLEASE ANSWER ALL QUESTIIONS BY MARKING AN "X" IN THE "YES" OR "NO" COLU7MN. COMMENT ON ALL "YES" RESPONSES IN THE SPACE PROVIDED. USE ADDITIONAL AN SHEET IF NECESSARY.

| | Yes | No | |
|---|---|---|---|
| 1. Has your physical activity been restricted during the past five years? (Give reasons and duration) | | | |
| 2. Have you received treatment/counseling for a nervous condition, personality, or character disorder, or emotional problem? (Give details) | | | |
| 3. Have you had any illness or injury or been hospitalized other than already noted? (Give details) | | | |
| 4. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? (Other than routine checkups) | | | |
| 5. Do you have any health problems that require periodic evaluation/testing? (Give details) | | | |
| 6. Are you now under medication or treatment? (List medication, dosage, type of treatment in the space below) | | | |
| 7. If you use needles (syringes) for medications, please check here so that we may have a puncture resistant container available for your use. | | | |

| **CONTINUING MEDICATIONS**: USE THIS SPACE FOR RESPONDING TO QUESTION 7 ABOVE. (Medications that are required by participants should accompany them on trips. | **Date Started** |
|---|---|
| | |
| | |

**IMMUNIZATION HISTORY:** SUPPLY THE DATE FOR EACH OF THOSE WHICH YOU HAVE HAD

| | DATE | | DATE |
|---|---|---|---|
| Diphtheria, Tetanus, Pertussis | | Pneumococcal | |
| Haemophilus Influenza Type B (HIB) | | Varicella | |
| Hepatitis B Vaccine | | Influenza* | |
| Inactivated Polio (IPV) | | Hepatitis A* | |
| Measles, Mumps, Rubella (MMR) | | Other (Specify) | |

This schedule includes the recommended childhood vaccines, as of December 1, 2001, for children through 18 years. *Indicates vaccines recommended for selected populations.

**HEALTH INSURANCE COVERAGE:** CHECK ALL THAT APPLY

Your primary health insurance company will be billed if you provide authorization to do so and present current plan enrollment information. If you belong to an HMO or PPO, you must obtain pre-authorization for care for your child from your health insurance carrier prior to receiving services. The health insurance plan will reimburse you directly for any covered benefits. You remain responsible for payment of the total amount of the charges incurred at any health facility.

| | |
|---|---|
| ( ) Blue Cross/Blue Shield | Subscriber's Name (Print) |
| ( ) MESSA | Relationship to Student |
| ( ) HMO/PPO (Plan Name) | Address |
| ( ) Student Insurance | |
| ( ) Medicaid | Policy/Contract Numbers |
| ( ) Medicare | |
| ( ) Other (Specify) | |
| ( ) None | Plan Phone Number (If pre-authorization is required for care) |

**STUDENT:**

Date of Last Physical Examination: _____

Signature of Student _____ Date _____

**PARENT OR GUARDIAN**

I hereby give my permission for such necessary and emergency care to be given to my son/daughter.

*(To be signed by parent/guardian of all applicants under 18 years of age)*

Signature of Parent/Guardian _____ Date _____