2017-2018 Pride of Bixby Medical Information Form

Student's Name____________________________GoesBy__________DOB_______
Student's Address________________________________City__________Zip______
Student's Cell (for emergency use)____
Mother's Name/Legal Gaurdian____
Email(Please make Legible)____
Home Phone__________________Work_________________Cell_______________
Father's Name/Legal Guardian____
Email(Please make Legible)____
Home Phone__________________Work_________________Cell_______________
Emergency Contact (If unable to reach Parent/Guardian)
Name_________________________________Relationship____________________
Best Phone Number to Reach____

Student Health Information

Physician__________________________Office #____________________________
Preferred Hospital ___________________Insurance Carrier____________________
Ins Group/ID________________________Gaurauntors Name__________________

Student Medical History-Check if Applicable

Diabetes_____Asthma_____Heart Condition_____Fainting____Seizures__________
High Blood Pressure_______Nose Bleeds_______Migraines_____Other__________
Surgeries____
Medical Conditions Not Listed____

ASTHMATICS NEED TO ALWAYS HAVE THEIR RESCUE INHALER WITH THEM AT ALL BAND FUNCTIONS *****YOU CANNOT BORROW A FRIENDS***

Student is Allergic to-Check all Applicable and Explain-**NO NONE ALLERGIES**___
Penicillin___Cephalosporin___Erythromycin___Sulfa___Tetracycline___Aspirin____
Other______________Explain Reaction_____________________________________
Nuts/Nut Products___Insect Stings___Milk___Dairy___Eggs___Other____________
Explain Reaction____

Date of Last Tetanus Shot____

MEDICATION LIST(Include daily, over the counter, vitamins and herbal supplements)

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Do you give permission for the Pride of Bixby Sponsors to Provide Over the Counter Medications-TYLENOL(acetaminophen),ADVIL/MOTRIN(Ibuprofen), ALEVE(Naprosyn), BENADRYL/CLARITIN/ZYRTEC(Antihistamines), antacids,anti diarrheal,cough drop,antibiotic ointment,motion sickness medication if it is available, and is requested by student?
YES______NO______EXCEPTIONS______________

Date_______________Signature____

Updated 7/2017

PRIDE OF BIXBY CONSENT FOR TREATMENT 2017-2018

STUDENT:______________________________Date of Birth_________________________

PART 1-TO GRANT CONSENT

If a simple medical problem arises, I hereby grant the trip sponsors, or a trained first aid provider the authority to administer simple medications/first aid while attending practices/performances/trips both at Bixby High School and location away from school. In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment necessary by a licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. I further understand, I will take full financial responsibility for all expenses, which might be incurred for medical issues beyond simple first aid,
Signature of Parent/Guardian__________________________________Date_______________

Any additional facts concerning the student's medical history that were not included on the first page that a PHYSICIAN should be alerted to____

PART 2-REFUSAL OF CONSENT
(Do not complete Part 2 if you completed Part 1)

I do **NOT** give my consent for emergency treatment of my student. In the event of illness or injury requiring emergency treatment, I wish for the school authorities to take the following actions:
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Signature of Parent/Gaurdian_______________________________Date_________

Updated 7/2017