DEMOULIN EDUCATIONAL CLINIC
Health Information Form
To be completed by Parent/Guardian of student – PLEASE PRINT LEGIBLY. If <u>any</u> medications are prescribed or an over-the-counter medication may need to be given, a doctor <u>must</u> complete the medication portion of this form (see reverse side).

Student's Name (LAST, FIRST):	Gender: M F	D/O/B:
Address:	City:	Zip:
Parent/Guardian Name:	Cell Phone:	
Address (if different):	Home Phone:	
City, State, Zip	Work Phone:	
Parent/Guardian Name:	Cell Phone:	
Address (if different):	Home Phone:	
City, State, Zip	Work Phone:	

Student's health insurance information – do not leave this blank! Use additional pages if necessary.

Insurance Company Name:	
Subscriber:	Group Number:
Contract Number:	Phone:
Address:	

Health history:

<u>Life-threatening</u> allergic reactions/allergies	(Y / N)	Urinary or Bowel Problems	(Y / N)
Asthma or wheezing	(Y / N)	Shortness of Breath	(Y / N)
Eczema / Rashes / Hives	(Y / N)	Mental Health Issues	(Y / N)
Seizures	(Y / N)	Menstrual Problems	(Y / N / N/A)
Heart Condition	(Y / N)	Dietary Restrictions	(Y / N)
Diabetes	(Y / N)	Allergy to Medications	(Y / N)
Bone or Joint Problems	(Y / N)	Bleeding Disorder	(Y / N)
Concussion or Head Injury	(Y / N) When?	Other:	

If you answered **YES** to any of the above questions, please explain (use additional sheets if necessary):

Is your child able to participate in the normal activities of Band Clinic? (Y / N) If no, explain:

Has your child been hospitalized in the past three months? (Y / N) If yes, explain:

Has your child had any recent operations or injuries? (Y / N) If yes, explain:

MEDICATIONS: DeMoulin Educational Clinics BY DEMOULIN REQUIRES A PHYSICIAN'S SIGNATURE FOR ADMINISTRATION OF <u>ALL</u> PRESCRIBED MEDICATIONS AND OVER-THE-COUNTER MEDICATIONS THAT MIGHT BE GIVEN. ALL MEDICATIONS MUST COME IN THEIR ORIGINAL CONTAINER WITH DOSAGE INSTRUCTION (FOR PRESCRIBER).

Medication needed or used (INCLUDING OVER-THE-COUNTER MEDICATIONS): List **first** medication: ☐ Student may carry/self-administer this medication	
Dosage:	Time(s) the medication is given:
Medications needed or used (INCLUDING OVER-THE-COUNTER MEDICATIONS): List **second** medication: ☐ Student may carry/self-administer this medication	
Dosage:	Time(s) the medication is given:
Medications needed or used (INCLUDING OVER-THE-COUNTER MEDICATIONS): List **third** medication: ☐ Student may carry/self-administer this medication	
Dosage:	Time(s) the medication is given:
Medications needed or used (INCLUDING OVER-THE-COUNTER MEDICATIONS): List **fourth** medication: ☐ Student may carry/self-administer this medication	
Dosage:	Time(s) the medication is given:
Physician/Clinician Signature:	**Date:**
If additional medications are needed or used, INCLUDING OVER-THE-COUNTER MEDICATIONS, please attach an additional copy of this form and fill out the student name and medication sections only.	
MEDICATION WAIVER: My child has (list relevant diagnosis) _____ and I have declined to send any medication(s) (use additional pages if necessary). Parent/guardian initial	
Additional conditions staff need to be aware of (such as seasonal/environmental allergies, reactions to insect stings or bites, fainting, etc.):	
Are glasses worn? (Y / N) Contacts? (Y / N)	Are glasses needed? (Y / N)
I hereby give permission for my child to attend DeMoulin Educational Clinics by DeMoulin and he/she may participate in all program activities. I also, if applicable, give permission for a designated adult to administer the medications as directed above. I further consent to and agree to the release of the personal medical information included on this form to any and all appropriate individuals in the administration of the medications indicated above and any medical care. In addition, I authorize the physician who prescribed the medications indicated above, and/or their representatives, agents and designees, to communicate information to appropriate individuals about my child's medical condition(s). **In an emergency, I hereby give permission for the staff to seek appropriate emergency care.** **I hereby release and hold harmless DeMoulin Educational Clinics by DeMoulin, its officers, agents, employees and independent contractors, from any liability or damages, and I hereby waive all claims or causes of action against DeMoulin Educational Clinics by DeMoulin, its officers, agents, employees or independent contractors, which may result from participating in this band clinic and/or the administration of any medical care.**	
Student Signature:_____ **Parent/Guardian Signature (if under 18):** _____	**Date:**