LAST Name (PLEASE PRINT)

MEDICAL TREATMENT FORM

PORTSMOUTH HIGH SCHOOL MUSIC DEPARTMENT

120 Education Ln, Portsmouth, RI 02871

1-401-683-2124

(ALL INFORMATION GIVEN IS CONFIDENTIAL)

Please be sure to fill out ALL information on the form, if it does not apply, please write N/A

_____	_____	M F	_____
Student Name	Date of Birth	Sex	Student Cell #
_____	_____		_____
Parent's / Guardian's Name	Home Phone		Cell Phone (Parent/Guardian)
_____	_____		
Address	City, State, Zip		

1. If a parent is not available in the unlikely case of an emergency, please notify: (please give two names other than parents)

_____		_____	
Primary Emergency Contact		Secondary Emergency Contact	
_____	_____	_____	_____
Relationship	Phone	Relationship	Phone

2. Physician's Name:_____ Phone:_____

***** PLEASE USE THE REVERSE SIDE OF THIS FORM TO LIST MEDICATIONS *****

3. Does this student have any **medical conditions** that he/she is being treated for? (Ex. diabetes, epilepsy, asthma) Yes____ No_____

   If yes, indicate medical condition: _____

   If asthmatic, does your son/daughter use an inhaler? Yes_____ No_____ If yes, name of inhaler: _____

4. Please indicate (Yes or No) if your son or daughter is allergic to the following:

   Ibuprofen (Advil) _____ Penicillin _____ Aspirin _____ Other Drugs _____ (please list)

   Bee stings _____ Food Allergy_____ Do they carry an EpiPen? Yes ____ No _____

   If "Yes" to any of the above, please describe the type of **reaction**: (hives, breathing difficulties, swelling, etc)

   _____

5. If it is felt that your son/daughter should have the medication listed below, may an official chaperone administer your son/daughter the medicine? (write "Yes" or "No" to each item)

   Cough Syrup _____ Cold/Allergy _____ Tylenol _____ Advil _____ TUMS/Pepto _____

   Imodium _____ Dramamine _____ Other (please indicate preference) _____

6. Date of last tetanus shot: _____

7. Please indicate health insurance information:

   Plan: _____ (If Blue Cross/Blue Shield, indicate MA / RI / Federal)

   ID Number_____ Subscriber's Name: _____

8. Suggestions from parents as to limitations or signs of health risks for chaperones to be aware of:

   _____

   _____

AUTHORIZATION: This Health History is correct insofar as I know and the student therein described has my permission, as legal/guardian, to engage in all prescribed activities, except as noted by me in the space provided above. In the event that I or the individuals listed above for emergency notification cannot be reached in an "emergency," I hereby give my permission to the physician selected by Mr. Rausch to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my son/daughter as named above.

Parent/Guardian Name: _____ Signature:_____ Date:_____
(PLEASE PRINT)

Portsmouth High School Student Medication Identification

Student Name:_____

Please list any medications your son/daughter takes on a regular basis. **Please be sure to send it with them.**

Indicate below the name of medication and the specific times of day to be taken:

Medication Name and Dosage	When To Take	Comments