MEDICAL TREATMENT FORM

PORTSMOUTH HIGH SCHOOL MUSIC DEPARTMENT
120 Education Ln, Portsmouth, RI 02871
1-401-683-2124

Last Name: _____ Student Cell# _____

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

_____ _____ _____
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 your son/daughter have any **illness** that he/she is being treated for? (Ex. Diabetes, epilepsy, asthma) Yes_____ No_____

   If yes, indicate illness: _____
   (All information given is confidential)
   If asthmatic, does your son/daughter use an inhaler? Yes_____ No_____ If yes, name of inhaler: _____

4. Please indicate if your son or daughter is allergic to the following: (yes or No)
   Ibuprofen (Advil) _____ Penicillin_____ Aspirin_____ Other Drugs_____

   Bee stings_____ Food Allergy_____
   If yes, 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 here, may an official chaperone administer your son/daughter the medicine? (Yes or No)
   Cough Syrup_____ Cold/Allergy pill_____ Tylenol_____ Advil_____ Something for upset stomach_____

   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 or RI)

   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 Signature:_____ Date:_____

Portsmouth High School Student Medication Identification

Student Name:_____ Student Cell#_____

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