

Quince Orchard High School
Health History
CONFIDENTIAL

Please print.

Student's Name _____

Date of Birth _____ Gender (check one) Male ___ Female ___

Address _____

City _____ State _____ Zip Code _____

Parent/Guardian Contact Information

Mother/Female Guardian's Name _____

Address _____

City _____ State _____ Zip Code _____

1st Phone # _____ 2nd Phone # _____

Father/Male Guardian's Name _____

Address _____

City _____ State _____ Zip Code _____

1st Phone # _____ 2nd Phone # _____

Health History (check all that apply)

___ Asthma ___ Ear Infections ___ Heart Disease

___ Diabetes ___ Epilepsy ___ Other

Please provide further specific information that may be helpful. _____

Allergies (check all that apply)

___ Animal ___ Insect Stings ___ Pollen

___ Food ___ Medicine/Drugs ___ Other

Please provide further specific information that may be helpful. _____

Other Health Conditions (check all that apply)

___ Emotional Disturbance ___ Fainting ___ Hearing Impairment

___ Special Diet ___ Motion Sickness ___ Wears Contacts

___ Wears Glasses ___ Nosebleeds ___ Other

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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Please provide further specific information that may be helpful. _____

Immunizations (please give dates of last immunization)

Tetanus _____ MMR _____ Hepatitis B _____

Is your child under the care of a physician? Yes No
Does your child have a condition requiring regular medication? Yes No
Is there any restriction on your child's activities? Yes No

If you answered "yes" to any of the above questions, please provide specific information that may be helpful. _____

I am the parent/guardian of _____. Should a medical emergency arise during my child's participation in a QOHS Band activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers listed below. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my alternate would cause, I consent to:

1. The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or the medical facility identified below or chosen by the adult in charged; and
2. The immediate administration of life-saving measures deemed necessary under the circumstances.

Insurance Information

Insurance Company _____

Policy Number _____

Policy Holder's Name _____

Policy Holder's Date of Birth _____

If I cannot be reached in the event of an emergency, the following person is authorized to act in my behalf.

Designated Alternate _____

Relationship to student _____

1st Phone # _____ 2nd Phone # _____

Preferred Medical Doctor/Facility _____

Doctor's Phone Number _____

Signature of Parent/Guardian

Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM