

**STUDENT MEDICAL INFORMATION FORM**  
**McKeesport Area High School Marching Band / Color Guard/ Winter Guard (2019-2020)**  
 FORM REVIEWED BY THE PA DEPT OF HEALTH/DIVISION OF SCHOOL HEALTH, 2017

Student Name: \_\_\_\_\_ Sex: Female / Male Date \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Grade \_\_\_\_\_

Home Address: \_\_\_\_\_  
 Street City State Zip Code

Mother's Full Name: \_\_\_\_\_ Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Father's Full Name: \_\_\_\_\_ Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Stepparent/Guardian's Full Name: \_\_\_\_\_ Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Mother's E-Mail: \_\_\_\_\_ Father's E-Mail: \_\_\_\_\_

Stepparent/Guardian's E-Mail: \_\_\_\_\_ Student's E-Mail: \_\_\_\_\_

Is the student currently under medical treatment?  YES  NO

If yes, give the nature of the treatment and the doctor's name and phone number:

\_\_\_\_\_

Is the student currently taking any medications?  YES  NO

If yes, will the student require medications during the rehearsals /Performances?  YES  NO

If yes, a separate medication administration form will need to be completed. Ask the PAWS teachers for a copy

List any special health needs of which the school nurse or medical personnel should be made aware.

(IE. Allergies, diabetes, heart condition, food allergies, Seizures, etc.)

Is your child allergic?  YES  NO If yes, please list all allergies: \_\_\_\_\_

If yes, have any of these allergies caused an anaphylactic reaction?  YES  NO

Date of last tetanus shot: \_\_\_\_\_

Name of Health Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
 Street City State Zip Code

Name of Guarantor: \_\_\_\_\_ Agreement #: \_\_\_\_\_

Name of Employer (if group insurance): \_\_\_\_\_ Group # \_\_\_\_\_

Employer Address: \_\_\_\_\_  
 Street City State Zip Code

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**FIRST AID/EMERGENCY TREATMENT AUTHORIZATION**

If the School or Marching Band Staff /school personnel cannot contact either parent/guardian, please list two relatives or friends who would have the authority to advise us regarding your child:

Name	Relationship to Child
Address	Phone

Name	Relationship to Child
Address	Phone

If EMERGENCY TREATMENT is required, school authorities, Band Director, school representative, or school designee will use their own judgment in sending the child to a hospital or doctor most easily accessible before the parent/guardian can be reached.

Name of preferred hospital:	
Name of preferred doctor:	

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail. The recommendation of the parent/guardian, as indicated above, will be respected as far as possible.

It is understood and agreed that the child and his/her parent/guardian shall hold harmless the McKeesport Area School District, Marching Band Staff, designated chaperone, and any registered nurse, from any and all lawsuits, claims, demands, expenses or costs arising out of the administration of / or failure to administer first aid or emergency treatment to the child while they are in our care for marching band practices or performances.

Parent/Guardian Signature	Date
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This medical form will be held in the Band Office. These forms will be shredded and destroyed at the end of the season.

Parent/Guardian Signature	Student Signature	Date
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