



2008-2009 Orange Park High School Bands

CONFIDENTIAL Student Emergency Information Form

Parents/ Guardian, Please complete all information to the best of your ability: PLEASE PRINT.

Office Use Only:

MB
CB/SB
JB
WG/IP

The following information is for use only in the case of an emergency. The information you provide will aid emergency and other healthcare professionals to best help your child in a moment of need. Please complete each section to the best of your ability. Any changes may be made at the parent or guardian's discretion as the change arises; please contact the Director prior to any traveling event – for security and privacy, any and all changes must be done in person.

STUDENT: _____ Social Security Number: * * * - * * -
Last First Middle

Date of Birth: _____ Circle Gender: M F Citizenship (if not US): _____

PARENT / Guardian Name(s): 1. _____ 2. _____

Relationship: 1. _____ 2. _____

Please denote which is the billing address for Insurance (if different):

Address 1: _____
Number/Street City State Zip

Home Phone: () _____ Work: () _____ Cell: () _____

Address 2: _____
Number/Street City State Zip

Home Phone: () _____ Work: () _____ Cell: () _____

EMERGENCY Contact Name: _____ Relationship: _____

Address: _____
Number/Street City State Zip

Home Phone: () _____ Work: () _____ Cell: () _____

MEDICAL HISTORY:

Physician Name: _____ Contact: () _____

Date of Last Tetanus Shot: _____ Blood Type (if known): _____ Permission to Receive Blood in Emergency: Y / N

Student Health Condition(s):	<i>(Circle One)</i>	<i>Please comment/list in appropriate row below:</i>
ASTHMA	YES NO	Inhaler?
ALLERGIES (airborne, food, medication, etc.)	YES NO	List:
BLOOD DISORDERS?	YES NO	Hemophilia? Other:
CHRONIC / RECURRING ILLNESS	YES NO	
DIABETES	YES NO	
HEART PROBLEMS	YES NO	
SEIZURES	YES NO	
OTHERS? (reactions, bees, ants, substances, etc.)	YES NO	List:

List all Current Medications & Dosage (MUST be sent in **Original Container**):

Below please detail any other physical, mental, or medical conditions that will need to be brought to the attention of the emergency care providers:

Over the Counter (OTC) Medications:

The Band Parent Organization will travel equipped with first aid capabilities. By circling Yes or No below, you are designating permission for the listed OTC medication to be given to your child, upon reasonable complaint and/or minor injury (scrape, minor cut, etc.), by an OPHS Bands Chaperone or Staff Member in accordance with the Manufacturer’s directions:

OTC Medications	<i>(Circle One)</i>			<i>(Circle One)</i>	
Aspirin	YES	NO	Ibuprofen	YES	NO
Benadryl (oral)	YES	NO	Intestinal Medication (Pepto, Tums, etc.)	YES	NO
Benadryl (topical)	YES	NO	Topical Antibiotic (Neosporin, etc.)	YES	NO
Decongestant (Sudafed, etc.)	YES	NO	Tylenol	YES	NO

Insurance Information:

Parent/Guardian’s Medical Insurance Carrier (billing address on front): _____

Policy No. _____ Group No. _____

Other: _____

Consent for Medical Treatment:

The student (patient), the Parent or Guardian listed above, and others whose signatures are notarized below do hereby *consent to any and all medical and surgical treatments, including anesthesia and operations*, which may be deemed advisable by his or her emergency physicians and/or surgeons. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient’s care be deemed advisable or necessary. We also agree that the patient, when admitted, is to remain in the hospital until his physician recommends the patient’s discharge. **This form will be used only in case of emergencies and after every reasonable effort is made to contact parents/guardians prior to admitting the patient for necessary treatment.** Consent is also given for release of information for insurance purposes and I submit authorization for responsible third part to pay, directly to the hospital, insurance benefits due me for services rendered.

Release of Liability:

The student (patient), the Parent or Guardian listed above, and others whose signatures are notarized below hereby authorize the Band Faculty, Staff, and Chaperones as approved and designated by Orange Park High School to seek medical attention and issue medication for the above student granted utilizing the limitations and permissions designated. I further agree to indemnify, protect and hold harmless, the officers, supervisors, servants, agents, employees, and all private persons or organizations volunteering services to supervise and chaperone students, utilized or employed by Orange Park High School, the School District of Clay County, and the Orange Park High School Band Parent Organization, from any claim or liability whatsoever, including, but not limited to, personal injury, property damage, court costs, attorneys’ fees and interest, howsoever caused, as a result of above student participating and traveling in the Orange Park High School Band Program.

******I UNDERSTAND THAT THIS DOCUMENT CONTAINS A RELEASE******

Parent/Guardian – Signature

Parent/Guardian – Signature

Parent/Guardian – Print Name

Parent/Guardian – Print Name

Student (Patient) – Print Name

Date (all)

Student (Patient) Signature

Subscribed and sworn to me this _____ day of _____.

State of Florida
County of _____
SEAL

NOTARY PUBLIC