2019-20 Chimera Winterguard
Student Medical & Health Form

IMPORTANT PLEASE READ: This form must be submitted prior to any participation with Chimera Winterguard. This Medical / Health form will be kept on file with the director. Make sure ALL blanks are completed. If an item does not apply to you, please put "N/A" in the blank to ensure accurate information**. Incomplete forms cannot be accepted. Please make sure that the primary and secondary contact is someone who can be contacted at any time while you are participating in a winterguard activity.**

Student's Full Name: _____ Birth Date: _____

Sex: _____ Year in school: _____ Age: _____

Primary Emergency Contact: _____ Home Phone: _____

Work Phone: _____ Cell: _____ Email: _____

Secondary Emergency Contact: _____ Home Phone: _____

Work Phone: _____ Cell: _____ Email: _____

Health History

1. Operations (within the last year) _____

2. Individual Health Concerns (Hyperventilation, seizures, fainting, etc) _____

_____

3. Tetanus (Date of last injection) _____

4. Student's Blood Type _____

5. Do you have, or have ever had any of the following?
Rheumatic Fever: _____ Diabetes: _____ Epilepsy: _____ Asthma: _____ Seizures: _____ Allergic reactions to stings: _____

6. Allergies (Medications, bee stings, latex products, **FOODS**, etc). PLEASE LIST ALL:
_____

_____

_____

7. List any medications that you will be taking on a regular basis. _____

_____

8. Are you presently under the care of a physician for any reason? _____

9. Medical Exemptions (Blood transfusions, etc.) _____

10. Student's Physician _____Physician's Phone _____ Hospital _____

LIMITED POWER OF ATTORNEY

In the event that a serious emergency arises, it may be necessary for a physician to attend to the student before the staff can reach the student's designated physician or parents. Such emergency care can be provided only if the student and a witness sign the following **Authorization to Provide Medical Treatment.** (All information below is required for emergency treatment of the student)

AUTHORIZATION TO PROVIDE MEDICAL TREATMENT

I hereby give the director, staff member, or other Chimera Winterguard official in charge limited power of attorney to act on my / my child's behalf and see that _____ (student's name) receives whatever medical treatment is necessary in the event of an emergency.

Family Insurance Company _____ Phone # _____ Policy # _____

Student Signature _____ Student SSN: _____

Parent Signature _____ Date: _____