ELHS Band Medical Form 2024-2025

Student's Full Name: **Date of Birth:**

Parent or Guardian: **Phone:**

Parent or Guardian: **Phone:**

Emergency Contact #1: **Phone:** **Relationship:**

Emergency Contact #2: **Phone:** **Relationship:**

INSURANCE (optional):

Insurance Company: **Policy #:** **Group #:**

Name of Primary Insured:

Primary Insured's Place of Employment: **Phone:**

EXISTING CONDITIONS:

Is your student diabetic? **YES** **NO**

Explain:

The student should be prepared to self-treat/regulate within reason.

Does your student have asthma? **YES** **NO** If so, does he/she use an inhaler? **YES** **NO**

****The student must carry their inhaler on their person*.**

Does your student have food or other allergies that require an Epi Pen? **YES** **NO**

Explain:

The student must carry their Epi Pen on their person.

Please explain your student's existing medical conditions. List known allergies and side effects:

MEDICATIONS: Please list any medications your student is currently taking. Include the name of the medication and dosages.

Medication	Dosage	Medication	Dosage
1.		3.	
2.		4.	

I authorize, East Limestone High School (Mr. Mark McChristian, Mrs. Michelle Priest or the Band Appointed Nurse), to administer over the counter medications (i.e., Tylenol, Advil, etc.) as needed for my child. **YES** **NO**

I authorize, East Limestone High School, to obtain medical care for my child in the event such care is needed. I understand that if possible, I will be contacted should my child require medical attention. I grant to a licensed physician or accredited hospital, permission to perform any medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for the payment of such care. I release the East Limestone High School, Limestone County School District, and its chaperones/employees from any damages, liability or loss resulting from their securing good faith medical care for my child. I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my son/daughter.

Printed Name of Parent/Guardian

Parent/Guardian Signature **Date**