Cosby Choral
Department Medical Form
2017-18

Student Name_____
Last First Middle

Age _____ Date of Birth _____ Social Security Number _____

Address _____
Street & Number City Zip

Parent/Guardian Names & Address

_____
Mother's Name Address City Zip

_____
Mother's Home Phone Work Phone Cellular Pager

_____
Father's Name Address City Zip

_____
Father's Home Phone Work Phone Cellular Pager

Emergency Contact (Other than parent or guardian)

_____
Name Address City Zip

_____
Home Phone Work Phone Cellular Pager

Student's Doctor_____
Name Office Phone Answering Service Phone

Medical History

Does student have a Medical Treatment Plan on file with Chesterfield County Schools? _____
If yes, a copy must be attached to this form. *Yes* *No*

Allergies Drug _____ Food _____ Insect Stings _____

Does student carry an "Epi Pen" or inhaler? _____
Name Dose

Describe reaction and treatment for allergy.

_____
_____
_____

Date Last Tetanus Shot _____

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Check if your student has any of the following.

Asthma _____	Chronic Ear Infections _____	Heart disease _____
Diabetes _____	Learning Disabilities _____	ADD _____
Seizures _____	Orthopedic Conditions _____	Migraines _____
Arthritis _____	Thyroid Disorders _____	Fainting _____

Describe their conditions, reactions and treatments in space below.

_____
_____
_____

Surgeries, Hospitalizations or Other Serious Injuries/ Conditions Not Listed Above

_____

Medications Taken

Name	Dose	Frequency of administration	Reason for taking
Name	Dose	Frequency of administration	Reason for taking

List med. if you allow your student to receive Tylenol or Advil from a chorus parent._____
med dose

ALL PRESCRIPTION MEDICATION MUST BE LEFT WITH THE DESIGNATED CHAPERONE DURING OVERNIGHT TRIPS. CHAPERONE WILL ADMINISTER MEDICATIONS LISTED ABOVE WHEN NEEDED.

HEALTH INSURANCE

_____
Company Policy Number Name of Policy Holder

YOU ARE REQUIRED TO ATTACH A FRONT & BACK COPY OF YOUR HEALTH INSURANCE CARD TO THIS FORM

I give permission for _____(son/daughter's name) to travel with the Cosby Choral Department on various trips throughout the school year. I give my consent to have my son or daughter treated should a medical emergency arise. I understand every effort will be made to contact me should an emergency arise.

Parent or Guardian Signature _____ Date _____

EMERGENCY CONTACT FORM

(to be left in the CHS main office)

PRINT neatly please!!!

Student Name

Parent/Guardian Name

Emergency Contact Phone Numbers

Parent Home Phone | Parent Cell Phone | Parent Work Phone