# Santa Fe High School "**Raider Regiment**" Medical Treatment Form

DUE BY JUNE 6TH, 2018

## Section A –Student Information

Student's Name: _____ Date of Birth _____ Age _____
Grade _____ Race_____ Sex_____ Social Security Number_____
Address: _____ City:_____ State: _____ Zip: _____
Email_____HomePhone:_____
Cell phone:_____ Emergency Phone:_____

## Section B-Parent/Guardian Information

Father/Guardian's Name: _____Work Phone _____
Cell Phone: _____ Email_____
Mother/Guardian's Name _____Work Phone _____
Cell Phone: _____ Email_____

## Section C- Emergency Contact Information Please list two other persons other than the parent/guardians to call in case of an emergency

1. Name: _____ Relationship: _____
Work phone_____ Cell Phone: _____
2. Name: _____ Relationship: _____
Work Phone _____ Cell Phone: _____

## Section D-Dietary Needs:

Do you require a vegetarian Meal? YES NO
Please list any special dietary requirements_____

## Section E- Medicines Please list medicines that the minor is currently taking Medication

Name, Dosage, Per day,

_____
_____
_____

## Section D - Medical History Please list any physical challenges and/or drugs to which the student may be sensitive

**Health History: Please Circle and Explain Below**

Concussion/head injury Cardiac Problems Diabetes Asthma Epilepsy/seizures Motion Sickness Epilepsy Seizures Fainting Spells Headaches/Migraines Hemophilia/Bleeding Disorder Nosebleeds Other

**Allergy: Please Circle and Describe Reaction/Please Specify**

Insect/bee sting Allergies: Food Allergies Medication Allergies Latex Allergies Other Allergies

_____
_____
_____

*Does the student have an inhaler or EpiPen? YES NO
Current Health Concerns or Restrictions:_____
Date of Student's Last Tetanus Shot: _____

## Section F-Heath Insurance: Please Make A Photo Copy of Insurance Card

Health History Does Student Have: Medical Insurance? Yes _____ No _____
Name of Insurance Company: _____
Insurance Policy#: _____
Physician's Name: _____ Phone#: _____

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Students that require emergency access to inhalers or other medications should have them with them always. Please be aware that the school requires a separate form for those students needing access to medications during the school day.

I fully understand the physician and other health care personnel will be acting in good faith and according to usual, acceptable medical practice. I also understand that every attempt will be made to notify the person(s) listed on this form in case of an emergency. I hereby grant permission for the attending physician, consulting physicians, and/or other health care personnel to render or administer emergency treatment, medical care, surgical care, appropriate medications, or hospitalization in an accredited facility that might be deemed necessary.

Parent/Guardian Signature_____Date_____

Witnessed this _____day of_____200_____