Santa Fe High School “Raider Regiment” Medical Treatment Form

DUE BY JUNE 5TH 2017

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#:
____

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.

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

Parent/Guardian
Signature____Date___________________
___

Witnessed this ____________day
of____200______________________

Signature of Notary
Public____Date___________________
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My Commission Expires: