

**STUDENT FORM-----KISKI AREA MUSIC DEPARTMENT FORM #2**  
**HEALTH HISTORY AND CONSENT FOR MEDICAL TREATMENT**

**Part I** All information must be completed

Student's Name \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Work / Cell# ( ) \_\_\_\_\_ Mother's Work/Cell # ( ) \_\_\_\_\_

Alternate Emerg. Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician : \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

**Part II** Check only items that apply

Kidney/Bladder		Heart disease		<b>Allergies:</b>
Sleepwalking		Convulsions		To Drugs (list)
Menstruation		Diabetes		
Headaches		Hernia		To Foods (list)
Constipation		Hay Fever		
Shortness of Breath		Other		To Insect Bites/Stings:
High Blood Pressure		Asthma		
Low Blood Pressure				List Insects:
Fainting				Normal treatment used at home:
Nose Bleeds				
Serious/Chronic Illness (List):				
Operations? (List):				
Contact Lens?			Date of last Tetanus: _____	(mm/dd/yy)
Any other medical or psychological conditions/info we should know?				
Note any current medications you are taking. If this information changes at any time, you agree update this form in writing.				
Medication Name/ Strength:			Taking for:	
Medication Name/ Strength:			Taking for:	
Medication Name/ Strength:			Taking for:	
Medication Name/ Strength:			Taking for:	
Any Special Dietary Requirements:				

Participant/Parents agree to update this form whenever circumstances change

**Part III** This section requires a full signature beside each medication you authorize KAIB to administer to your child. NO INITIALS..... full signature only.

By signing below, I authorize the adult in charge or designated personnel to administer the following medications to (Child's name) \_\_\_\_\_ should he/she need/request them.

**(Full Signature Required)**

Advil/Ibuprofen, Tylenol, Pamprin	
Tums/Roloids	
Throat Lozenges, Cough Drops, Salt Water Gargle	
Peroxide, Bactine, Topical Antiseptic, Sunburn Lotion	
Insect Bite/Sting (Topical)	
Benadryl/ Diphenhydramine (25 mg)	
Saline Solution/ Contact Soln	
Dramamine	
Imodium / Kaopectate	
Others (List)	

**COMPLETE BACK ALSO**

DOB: \_\_\_\_\_

Name: \_\_\_\_\_

**INJURY RISK CONTRACT**

**CIRCLE GRADES THAT YOU PARTICIPATED IN MARCHING BAND, INCLUDE THIS SEASON**

**7      8      9      10      11      12**

**Section I:** Parent/guardian permit: I hereby give my consent for the above named to participate in said marching band at Kiski Area High or Intermediate School, and give my permission for him/her to participate in any travel associated with the marching band as authorized by the school district.

PARENT / GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

**Section II:** Insurance waiver and release from liability: We, the undersigned parents/guardians, agree that the Kiski Area School District and its agents and/or employees shall be in no way responsible for any injuries suffered by our child(ren) while engaged in any band activity sponsored by the Kiski Area High School District. Further, we hereby release the aforesaid of any and all liability for such injuries. This action is being taken in view of the fact that he/she is already covered by the following:

PARENT / GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF INSURANCE POLICY

POLICY NUMBER

**Section III:** Injury risk: Every participant and their parents are hereby advised that participation in marching band involves strenuous physical activity and interstate and intrastate travel posing the danger of injury and illness to band participants. The undersigned and his/her parent(s)/guardian(s) acknowledge and **assume the risk** of such dangers, and by their signature hereto indicate their willingness to voluntarily participate in the marching band activity with full knowledge of possible dangers, including bodily injury and illness.

STUDENT \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT / GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

**Part IV (Parental/guardian Consent for Emergency Medical Treatment)**

In case of illness, accident or an emergency, I authorize the band director, or assigned personnel, to secure any necessary medical/dental treatment for \_\_\_\_\_ while he/she is participating in any activity of the Kiski Area Music Department. I also guarantee payment of all charges incurred during this medical/dental treatment (including, but not limited to: Physician, Dentist, Hospital, X-Ray, Lab, Drugs, Ambulance, Etc.) . I hereby authorize any agent of the Kiski Area Band Boosters responsible for student welfare to access this information for my child's or my well-being.

Signature of  
PARENT / GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

**Information@Kiskiareaband.com**