

Student's Last Name

Student's First Name

School Year

**Health Information Form  
University High School Band & Guard**

Student's Date of Birth: \_\_\_\_\_

Student's Address: \_\_\_\_\_

**Parent Information**

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

Father's Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Father's Address: \_\_\_\_\_

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

Mother's Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Mother's Address: \_\_\_\_\_

**Health Insurance Information**

No health insurance at this time: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Insurer's Address: \_\_\_\_\_

Group #: \_\_\_\_\_ ID or Subscriber #: \_\_\_\_\_

Type of Insurance: Private \_\_\_\_\_ Group \_\_\_\_\_ **Attach a copy of insurance card**

**Emergency Contact Other Than Parent(s)**

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

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

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Student's Last Name \_\_\_\_\_

Student's First Name \_\_\_\_\_

School Year \_\_\_\_\_

### Health History

Please check/list all that apply and explain below. If there is a treatment, please give detailed description.

Drug Allergy (list) \_\_\_\_\_

Asthma \_\_\_\_\_

Food Allergy (list) \_\_\_\_\_

Heart Problem \_\_\_\_\_

Insect Bite Allergy (life threatening) \_\_\_\_\_

Muscular/Skeletal Problem \_\_\_\_\_

Serious Injury/Surgery \_\_\_\_\_

Gastrointestinal Problem \_\_\_\_\_

Medical Problem \_\_\_\_\_

ADHD \_\_\_\_\_

Seizure Disorder (type) \_\_\_\_\_

Other \_\_\_\_\_

Fainting (frequent) \_\_\_\_\_

Current Medications: \_\_\_\_\_

Details and/or Treatment Information: \_\_\_\_\_

Physical activities to be restricted (include details): \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Student's Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

### Authorization for Over the Counter Medicine and Medical Treatment

*I confirm that I am the legal parent/guardian of \_\_\_\_\_ and I give my permission for University High School Band volunteers to administer the following over the counter medications (name brand or generic) to my child as indicated below.*

Initial each	Medication/Symptoms
	Tylenol: Mild to moderate aches, pains, headaches
	Claritin (Loratadine): Allergies
	Benadryl: Alergic reactions*
	Sudafed: Nasal congestion
	Tums/Mylanta: Upset stomach
	Imodium: Diarrhea

Initial each	Medication/Symptoms
	Hydrocortisone Cream: Contact dermatitis
	Cough Drops: Cough
	Cepacol: Mild sore throat
	Saline (Artificial Tears): Eye irritations
	Dramamine: Motion sickness*
	Neosporin: Minor cuts/abrasions

*This is to authorize a hospital or physician to render emergency medical care to my son/daughter/ward \_\_\_\_\_ in the event of an emergency and I am (or other emergency contact is) unable to be reached. I grant permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic. The signature below also authorizes chaperones to administer first aid treatment as required during band functions.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EMERGENCY TREATMENT AUTHORIZATION CARD-English** SCHOOL BOARD OF ORANGE COUNTY, Florida (Please Print)

Student's Legal Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Student's Date of Birth: \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

My child is allergic to the following medications: \_\_\_\_\_  
 My child has the following allergies: \_\_\_\_\_

Please identify any serious injuries or illnesses your child has had: \_\_\_\_\_

Alternate family member/friend to contact in case of emergency Name: \_\_\_\_\_  
 Telephone Number (s): \_\_\_\_\_

Primary Care Doctor Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

You understand that the insurance offered by Orange County Public Schools is a secondary policy and will pay only after your personal insurance pays.

Please write "none" if you have no personal insurance on this student.  
 Primary Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Insurance Company Address: \_\_\_\_\_

You understand if a parent, guardian or student falsifies any signature or information on the emergency medical treatment card, the student will be declared ineligible to participate in any Orange County interscholastic activity for one full calendar year from disclosure date. You further give your permission for appropriate school staff and their designees to render medical treatment or authorize medical treatment by a hospital and/or doctor and agree to hold the School Board and its employees harmless in the administration of such assistance. I hereby acknowledge and certify that I have read the emergency medical document, that I understand and agree with its terms. Florida Statutes (92.525) "Under penalties of perjury, I declare that I have read the foregoing and that the facts stated in it are true." I agree to be bound by its terms and I have reviewed and explained the notice with my child.

\_\_\_\_\_  
 Signature of Parent/Legal Guardian Print Name of Parent/Legal Guardian Date

Telephone (H) \_\_\_\_\_ Telephone (W) \_\_\_\_\_ Other \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Email Address \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**TARJETA DE AUTORIZACIÓN PARA TRATAMIENTO DE EMERGENCIA-ESPAÑOL** JUNTA ESCOLAR DEL CONDADO ORANGE, FLORIDA (Letra de Molde)

Nombre Legal del Estudiante: \_\_\_\_\_ Escuela: \_\_\_\_\_ Grado: \_\_\_\_\_  
 Fecha de Nacimiento del Estudiante: \_\_\_\_\_ Fecha de la última vacuna contra el tétano: \_\_\_\_\_

Mi hijo(a) es alérgico a las siguientes medicinas: \_\_\_\_\_  
 Mi hijo(a) tiene las siguientes alergias: \_\_\_\_\_

Favor de identificar cualquier lesión seria o enfermedades que su hijo(a) ha tenido: \_\_\_\_\_

Miembro de familia/Amigo alterno que pueda contactarse en caso de emergencia: \_\_\_\_\_  
 Nombre: \_\_\_\_\_ Números de teléfono: \_\_\_\_\_  
 Nombre del Médico de Cuidado Primario: \_\_\_\_\_ Teléfono: \_\_\_\_\_

Usted comprende que el seguro ofrecido por las Escuelas Públicas del Condado Orange es una póliza secundaria y pagará sólo después de que haya pagado su seguro personal.

Por favor escriba "ninguno" si no tiene seguro personal para este estudiante.  
 Compañía Primaria de Seguros: \_\_\_\_\_ Número de Póliza: \_\_\_\_\_  
 Dirección de la Compañía de Seguros: \_\_\_\_\_

Usted comprende que si un padre, encargado o estudiante falsifica cualquier firma o información en la tarjeta para tratamiento médico de emergencia, el estudiante será declarado inelegible para participar en cualquier actividad interescolar del Condado Orange durante un año calendario completo a partir de la fecha del descubrimiento. Usted adicionalmente concede su permiso para que el personal apropiado de la escuela y sus asignados ofrezcan tratamiento médico o autorice tratamiento médico por parte de un hospital y/o médico y acepta librar a la Junta Escolar y sus empleados de responsabilidad en la administración de tal asistencia. Por la presente reconozco y certifico que he leído el documento de evaluación deportiva, que comprendo y acepto sus términos. Estatuto de Florida (92.525) "Bajo pena de perjurio, declaro que he leído lo anterior y que los hechos presentados son verídicos. Acepto estar sujeto a sus términos y he revisado y explicado la notificación a mi hijo(a).

\_\_\_\_\_  
 Firma del Padre/Madre/Encargado Legal Nombre del Padre/Madre/Encargado Legal Fecha

Teléfono (H) \_\_\_\_\_ Teléfono (O) \_\_\_\_\_ Otro: \_\_\_\_\_  
 Dirección: \_\_\_\_\_  
 Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_

# Orange County Public Schools

P.O. Box 271  
Orlando, FL 32802

## Model Release Form

### CONSENT, WAIVER AND RELEASE

For and in consideration of benefits to be derived from the furtherance of the educational programs of the School Board of Orange County, Florida, (I) (We), personally and on behalf of \_\_\_\_\_ the undersigned parent(s) or legal guardians of \_\_\_\_\_, a student entered in the Orange County School System, do hereby consent, authorize and grant permission to the School Board of Orange County, Florida, its agents, employees or duly authorized representatives to take photographs, motion pictures or video tapes of said student, and do further consent to the publication, circulation and dissemination of said photographs, motion pictures or video tapes or any duplication or facsimile thereof for any purposes it may deem proper, including but not limited to use on the internet.

In granting such permission, (I) (We) hereby relinquish and give to the School Board of Orange County, Florida, all right, title and interest (I) (We) may have in the pictures, negatives, reproductions or copies, and further waive any and all right to approve the use of such photographs, motion pictures or video tapes and further do waive any right to compensation for the publication or other use of said photographs, motion pictures or video tapes and do release the School Board of Orange County, Florida, its agents, licensees, representatives and assigns from any and all claims of any nature whatsoever arising from their use.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Permanent Address \_\_\_\_\_  
(Number/Street) (City) (State) (Zip Code)

Relationship \_\_\_\_\_ Phone \_\_\_\_\_