

**CLAIRTON MARCHING BAND**  
*Clairton Education Center*  
501 Waddell Ave. Clairton, PA 15025  
David Geckle - Director

**PERSONAL HEALTH HISTORY**

To be filled out by parent or guardian. PLEASE PRINT IN INK.

Name of Band Member \_\_\_\_\_ . D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Home Phone # \_\_\_\_\_

Home Address \_\_\_\_\_ Work Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

CHECK ALL ITEMS THAT APPLY, PAST OR PRESENT TO YOUR HEALTH HISTORY.  
PLEASE EXPLAIN ANY YES ANSWER.

GENERAL INFORMATION

Asthma	_____ YES	_____ NO	Convulsions/Seizures	_____ YES	_____ NO
Heart Trouble	_____ YES	_____ NO	High Blood Pressure	_____ YES	_____ NO
Diabetes	_____ YES	_____ NO	Cancer/Leukemia	_____ YES	_____ NO
Hemophilia	_____ YES	_____ NO	Kidney Disease	_____ YES	_____ NO
Allergies:	Food, Medicines, Insects or Plants		_____ YES	_____ NO	

EXPLANATION:

\_\_\_\_\_

List any medications to be taken and times

\_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation:

\_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

Name of Personal Physician: \_\_\_\_\_

Personal Health/Accident Insurance carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

PARENTAL AUTHORIZATION:

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activity, except as noted. In the event of illness or accident in the course of such activity, I request that measures be instituted without delay as the judgment of medical person dictates.

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

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**PARENTAL AUTHORIZATION FOR TREATMENT**

I/We \_\_\_\_\_  
(Name of Parents/Guardian)  
Of \_\_\_\_\_  
(Address)

Parents/Guardian of \_\_\_\_\_, do hereby grant permission to  
(Name of Student)

Mr. Geckle and/or the Honeybear coordinator and the Clairton Education Center to authorize to perform medical, surgical or emergency treatment at the closest facility and in the best interest of my/our child, who was born on \_\_\_\_\_.

This authorization is given with the understanding that the Custodian or Temporary Guardian will act in place of our absence, the parents/guardians, during the period of time that the child is with the band at an event, from July 2018- July 2019. This authorization is granted for the benefit of my/our child above named, and the Grantors of this authorization will hold the Custodian or Temporary Guardian harmless for any and all medical or hospital treatment resulting from the use of this authorization. I/We, the undersigned, authorize the Custodian of Temporary Guardian, above named, to give such information concerning me/us, the parents/guardians, as may be necessary for proper treatment of my/our child.

**PARENTAL AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION**

I hereby authorize the Clairton Band Boosters to administer non-prescription medication as needed to my/our child during any band activities.

This authorization is granted for the benefit of my/our child and the grantors of this authorization will hold Mr. Geckle, the Honeybear Director and/or the Clairton Band Boosters harmless for any results from the use of this authorization.

PLEASE INDICATE (BY INITIALING) WHICH TYPE OF MEDICATION YOU WISH YOUR CHILD TO RECEIVE:

\_\_\_\_\_ TYLENOL (ACETAMINOPHEN)

\_\_\_\_\_ ADVIL (IBUPROFEN)

\_\_\_\_\_ DRAMAMINE

\_\_\_\_\_ BENADRYL

Parents/Guardians Signature \_\_\_\_\_ Date \_\_\_\_\_