

REQUIRED FOR SOUND TO SEA PARTICIPATION

Name _____
School _____

Student Medical Form

Name _____ Age _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____ - ____ - ____ Sex ____ Weight _____ Height ____ ft ____ in

Parents or Guardians _____	
Home Phone (____) _____ - _____	Work Phone (____) _____ - _____
Home Phone (____) _____ - _____	Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____	Cell Phone (____) _____ - _____
Family Physician/Doctor _____	Phone (____) _____ - _____
In case of emergency, notify the following if a parent cannot be reached:	
Name _____	Relationship _____ Phone (____) _____ - _____
Name _____	Relationship _____ Phone (____) _____ - _____

**These must
be filled in.**

Home and Health Questionnaire

1. Please give the date of the student's last diphtheria-tetanus or tetanus booster _____.
2. Please list any current activity restrictions or special health concerns such as recent sprains, fractured bones, recent hospitalizations, learning disabilities, physical disabilities, special diet (vegetarian/religious restrictions) _____

3. Does the student have a history of: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional/psychological condition | <input type="checkbox"/> Musculoskeletal disorder |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart defect/disease | <input type="checkbox"/> Homesickness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Other health conditions: |
| <input type="checkbox"/> Ear/Throat infections | | |

Explain the health conditions checked above: _____

4. Please tell us if your student has any allergies: (Food, Medication, Insect Bite/Sting, Seasonal, Other)

My child is allergic to _____
It is an allergy of (circle all that apply) **ingestion, contact, inhalation, other** _____
The **severity of the reaction is** (hives, stomach ache, anaphylactic reaction, etc) _____

Recommended **treatment** for reaction _____

My child is **ALSO** allergic to _____
It is an allergy of (circle all that apply) **ingestion, contact, inhalation, other** _____
The **severity of the reaction is** (hives, stomach ache, anaphylactic reaction, etc) _____

Recommended **treatment** for reaction _____

Please list any additional allergies on the back of this form.