Castle Band Medical Form

Castle High School, Newburgh, IN - Warrick County School Corporation

Student Full Name _________________________________ Graduation Year _______Birthdate _________

Cell Phone _____________________ Home Phone ________________________Fall of 2024 Grade______

Student Address _________________________________City ______________________State _______

Father/Guardian ___________________________ Mother/Guardian ___________________________

Cell Phone _________________________________ Cell Phone _________________________________

Home Phone ______________________________ Home Phone _______________________________

Place of Employment _______________________ Place of Employment ________________________

Date of Student's Last Tetanus Injection ____________________________

Physician's Name ___________________________________ Phone Number ____________________

Insurance Company _________________________________ Policy Number ______________________

List Medications currently taking:

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List reasons for taking medication:

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List Allergies:

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Special Dietary Needs:

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<u>OTHER CONTACT INFORMATION</u> (if different than above)

Emergency Contact #1 _________________________ Emergency Contact #2 _______________________

Relationship _________________________________ Relationship _______________________________

Cell Phone __________________________________ Cell Phone _________________________________

Home Phone ________________________________ Home Phone _______________________________

In case of accident or serious illness, parents/guardians/relatives/friends will be contacted. If they cannot be contacted, and the above named needs emergency medical treatment, consent is hereby given for such emergency treatment as may be considered necessary in the opinion of the attending physician. Authorization is also given for any of the listed medications on this form to be administered, if necessary, to the above named individual.

Signature (digital or handwritten) ______________________________________ Date__________________