

HEALTH HISTORY RECORD
2024 Dundee High School Marching Band Camp

Dear Parent:

The following information is requested so that the Dundee High School Band Director and Staff can better meet the physical, intellectual, and emotional needs of your student. Fill out the information requested.

Student Name (Last)		First		Middle		Phone Number	
Address (Number and Street)				*Sex	Gender	Date of Birth	
Parent or Guardian's Name (Last)		First		Middle		Phone Number	
Address (Number and Street)			City		Zip	Phone Number (emergency)	
Parent or Guardian's Name (Last)		First		Middle		Phone Number	
Address (Number and Street)			City		Zip	Phone Number (emergency)	
Is the student having any of the problems listed below?				Yes	No	Yes	No
1. Hay fever, asthma, or wheezing						6. Frequent colds, ear aches	
2. Eczema or frequent skin rashes						7. Shortness of breath	
3. Convulsions/seizures						8. Dizziness/Fainting	
4. Heart Trouble						9. Allergies (Medication, Environmental)	
5. Diabetes						10. Other	
Please explain any problem areas identified above:							
Operations or injuries:							
<input type="checkbox"/> Check if none							
Explain any special health, behavioral, or emotional considerations:							
<input type="checkbox"/> Check if none							
Are the student's immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Does the student have any restrictions or limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, explain the degree of restriction							
I certify that this information is correct to the best of my knowledge				Signature of Custodial Relationship Parent/Guardian			Date

*Sex assigned at birth

MEDICAL AUTHORIZATION
2024 Dundee High School Marching Band Camp

Name of Student (Print Last Name, First Name)		
Primary Emergency Contact Information:	Secondary Emergency Contact Information	
Emergency Contact Instructions (if applicable):	Primary Care Physician Name and Contact Information:	
<p>I hereby give permission to the marching band camp operators named below to secure medical and/or surgical treatment and to provide routine, non-surgical medical care for the student named above while attending band camp:</p> <p style="margin-left: 40px;"> Jaymi Yettaw, Dundee High School Band Director Elizabeth Danzeisen, Dundee High School Band Camp Coordinator James Reppert, Dundee High School Band Medic Jon Schwab, Dundee High School Band Camp Chaperone Keli Plansinis, Dundee High School Band Camp Chaperone Nicki Taylor, Dundee High School Band Camp Chaperone </p>		
<p>PARENT/GUARDIAN AUTHORIZATION FOR HEALTHCARE:</p> <p>This health history is correct and accurately reflects the health status of the student to whom it pertains. The student described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the medical professional selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the selected medical professional to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this student. I understand the information on this form is strictly confidential and will be shared on a "need to know only" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child, and these providers may talk with the above listed camp operators about my child's health status.</p>		
Signature of Custodial Relationship Parent/Guardian	Relationship to Student:	Date

MEDICATION RECORD

2024 Dundee High School Marching Band Camp

Student Name (Last)	First	Middle Initial	Gender	Date of Birth
Allergies (Medication or Environmental)				

NOTE: Please complete the fields titled: Name of Medication, Dose/Amount, Frequency, and Time of Day (for administration)

				08.04.24	08.05.24	08.06.24	08.07.24	08.08.24	08.09.24		
Name of Medication <i>Example: Multivitamin</i>	Dose/Amount <i>One tablet</i>	Frequency <i>Once a day</i>	Time of Day <i>9 a.m.</i>	<div style="border: 1px solid black; padding: 5px;"> <i>Note: Medic will mark down when medication was given to your student in this section</i> </div>							
Name of Medication	Dose/Amount	Frequency	Time of Day								
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I certify that this information is correct to the best of my knowledge	Signature of Custodial Relationship Parent/Guardian	Date
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Please print additional pages (if needed)

ADDITIONAL MEDICATION RECORD
2024 Dundee High School Marching Band Camp

Student Name (Last)	First	Middle Initial	Gender	Date of Birth
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NON-PRESCRIPTION (OVER-THE-COUNTER) AUTHORIZATION

The following information is requested so that the Camp Operators can better meet the medical needs of your student. If any over-the-counter medications are administered, they will be given as needed and in accordance with the medication recommendations and directions for use listed on the package label or insert. Examples of available non-prescription, over-the-counter medications include (but are not limited to): Tylenol (Acetaminophen), Motrin (Ibuprofen), Benadryl (Diphenhydramine), and Topical Relief Creams, Gels, and/or Rubs (Capsaicin/Menthol/Camphor).

I authorize camp staff to provide non-prescription, over-the-counter medications if they are needed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, with the exception of the following medication(s) that are NOT permitted to be administered:	
Signature of Custodial Relationship Parent/Guardian	Date

NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION RECORD

		08.04.24	08.05.24	08.06.24	08.07.24	08.08.24	08.09.24
****For Band Camp Medic's Use Only Non-Prescribed (Over-the-Counter) Medication Administration****							
Name of Medication	Dose	Time/Medic Initial					
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Medic Name James Reppert, MSN RN EMT-B NPD-BC CCRN CEN	Medic Signature						Medic Initials
Approved Camp Operator (ACO) Name	Approved Camp Operator (ACO) Signature						ACO Initials