

# J.M. HANKS HS BAND MEDICAL HISTORY & PHYSICAL EXAM FORM

Student's Last Name, First Name, MI		Social Security Number		Sex M    F		Grade		Date of Birth /   /																																																																																		
Parent or Guardian Names (First and Last)				Home Phone (   )		Father's Work Phone (   )		Mother's Work Phone (   )																																																																																		
Home Address (please include apartment number, if needed)																																																																																										
City		State		Zip		Please list other emergency Cell Phone or Pager Number(s)																																																																																				
Family Insurance Company:				Name of Insured:			Policy ID Number:																																																																																			
Prescription/Drug ID Number (if different):			Family Physician's Name:				Physician's Phone Number:																																																																																			
<p><b>Parent or Guardian please fill out the following information and explain any YES answers.</b></p> <p><b>Medical History</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th></th> <th>YES</th> <th>NO</th> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>A. Bleeding Tendencies</td> <td></td> <td></td> <td>I. Contact Lens/ Glasses</td> <td></td> <td></td> <td>Q. Sickle Cell Anemia</td> <td></td> <td></td> </tr> <tr> <td>B. High Blood Pressure</td> <td></td> <td></td> <td>J. Bone/ Joint Injury or Disease</td> <td></td> <td></td> <td>R. Hepatitis</td> <td></td> <td></td> </tr> <tr> <td>C. Heart Disease</td> <td></td> <td></td> <td>K. Neck Injury</td> <td></td> <td></td> <td>S. Rheumatic Fever</td> <td></td> <td></td> </tr> <tr> <td>D. Asthma</td> <td></td> <td></td> <td>L. Head Injuries</td> <td></td> <td></td> <td>T. Diabetes</td> <td></td> <td></td> </tr> <tr> <td>E. Surgery</td> <td></td> <td></td> <td>M. Concussions</td> <td></td> <td></td> <td>U. Emotional/ Psychological</td> <td></td> <td></td> </tr> <tr> <td>F. Body Part Removed Non-Funct.</td> <td></td> <td></td> <td>N. Skin Disease</td> <td></td> <td></td> <td>V. Seizures/ Convulsions</td> <td></td> <td></td> </tr> <tr> <td>G. Hernia</td> <td></td> <td></td> <td>O. Allergies</td> <td></td> <td></td> <td>W. Regular Medications</td> <td></td> <td></td> </tr> <tr> <td>H. Kidney Disease/ Injury</td> <td></td> <td></td> <td>P. Tuberculosis</td> <td></td> <td></td> <td>X. Under a Physician's Care?</td> <td></td> <td></td> </tr> </tbody> </table>											YES	NO		YES	NO		YES	NO	A. Bleeding Tendencies			I. Contact Lens/ Glasses			Q. Sickle Cell Anemia			B. High Blood Pressure			J. Bone/ Joint Injury or Disease			R. Hepatitis			C. Heart Disease			K. Neck Injury			S. Rheumatic Fever			D. Asthma			L. Head Injuries			T. Diabetes			E. Surgery			M. Concussions			U. Emotional/ Psychological			F. Body Part Removed Non-Funct.			N. Skin Disease			V. Seizures/ Convulsions			G. Hernia			O. Allergies			W. Regular Medications			H. Kidney Disease/ Injury			P. Tuberculosis			X. Under a Physician's Care?		
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<p>This physical exam must be completed before a student participates in any band practice or performance. I hereby give my consent for my son, or daughter, to practice, perform, and travel with the directors or other representative of the school. If, in the judgement of any representative of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment. Any treatment to the student by any physician, athletic trainer, nurse, hospital, or school representative, may be given. I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. It is understood that there is risk involved by participating in band and the school district cannot offer any guarantees against the possibility of an injury, either minor or more serious in nature. Neither the school nor the school district assumes any responsibility in case an accident occurs.</p>																																																																																										
Signature of Student _____					Date _____																																																																																					
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<b>MEDICAL REPORT: TO BE COMPLETED &amp; SIGNED BY A PHYSICIAN</b>	
Height _____ Weight _____ Pulse _____ Blood Pressure ____/____ Vision L____/____ R____/____ Hearing _____ Nose _____ Throat _____ Teeth _____ Neurological _____ Lungs _____ Heart _____ Liver _____ Spleen _____ Genitalia _____ Hernia _____ Urinalysis _____ Skin (Fungus? Staph?) _____	
<b><u>JOINT / MUSCULO-SKELETAL</u></b>	
Head/Neck/Spine _____ Shoulders/Chest _____ Arms/Elbows/Forearms _____ Wrists/Hands _____ Hips/Legs _____ Knees _____ Shins/Ankles/Feet _____	
<p><b>I certify that I have given this student a physical exam and he/she may compete in all supervised school band activities.</b></p>	
Date of Examination: _____	Physician's Phone Number: _____
Print or Type Physicians Name	
Physician's Address	
<b>Signature of Physician</b>	