

**STUDENT HEALTH HISTORY**  
**Mankato Area 77 Lancers**

Please  
 Staple or tape  
 Current picture  
 of Lancer here.

Instrument/Position \_\_\_\_\_

**STUDENT'S FULL NAME** \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Current Address \_\_\_\_\_

**PARENT/GUARDIAN**

Father/Guardian's Name \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

**IF PARENT/GUARDIAN CANNOT BE REACHED, PLEASE CALL:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Name of Physician/Clinic** \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Name of Dentist/Clinic** \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

**HEALTH HISTORY:** (Please give dates where known)

**Date of last tetanus shot** \_\_\_\_/\_\_\_\_/\_\_\_\_

Surgery (within the last year – date and what for) \_\_\_\_\_

Serious medical problems \_\_\_\_\_

Any special health problems in the past? \_\_\_\_\_

Emotional problems (hyperventilation, anxiety, depression) \_\_\_\_\_

Are there any muscle disorders, back problems, sore joints, recently broken bones, knee problems, (or the like?) \_\_\_\_\_

List even minor problems that may affect strenuous physical movement. \_\_\_\_\_

**Allergies: (bee/insect, medications, food, latex, other)**

| Allergy | Symptoms | Treatment (EpiPen, Benadryl) |
|---------|----------|------------------------------|
|         |          |                              |
|         |          |                              |
|         |          |                              |

**Medications:**

Are you currently taking any medication on a regular basis? Yes \_\_\_\_ No \_\_\_\_

If yes, answer the following:

| Medication | Dosage | When Taken | For |
|------------|--------|------------|-----|
|            |        |            |     |
|            |        |            |     |
|            |        |            |     |

**Medical History:**

Place an "X" next to any of these symptoms you may have, whether sometimes or frequently:

|  | Asthma                | Inhaler? | Yes | No | Mild                             | Moderate | Severe |
|--|-----------------------|----------|-----|----|----------------------------------|----------|--------|
|  | Diabetes              | Insulin? | Yes | No |                                  |          |        |
|  | Seizures              |          |     |    | Chest pains, shortness of breath |          |        |
|  | Blood Disorder        |          |     |    | Headaches – Frequent / Severe    |          |        |
|  | Ears/Hearing Problems |          |     |    | Kidney / Bladder Conditions      |          |        |
|  | Eyes/Vision Problems  |          |     |    | Nose Bleeds (frequent)           |          |        |
|  | Heart Conditions      |          |     |    | Stomach/Intestinal Conditions    |          |        |
|  | Hives                 |          |     |    | Sunburns Easily                  |          |        |
|  | Hernia                |          |     |    | Dental Problems                  |          |        |
|  | High Blood Pressure   |          |     |    |                                  |          |        |
|  | Other:                |          |     |    |                                  |          |        |
|  | Comments:             |          |     |    |                                  |          |        |

**I give my permission for my child to receive emergency, medical, dental or surgical treatment in the event of illness or injury.**

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

**Insurance: (Please staple or tape a current copy of insurance card here front & back)**

Company Name \_\_\_\_\_ Policy # \_\_\_\_\_

Company Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Agent's name, or name of company for group policy \_\_\_\_\_

Agent or company benefits office phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Agent or company benefits office phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Member is insured under: Father's Policy \_\_\_\_\_ Mother's Policy \_\_\_\_\_ Other (explain) \_\_\_\_\_

Students are expected to self-medicate.

\_\_\_ Check here if you prefer having a member of the staff or chaperones administer any medications. Medications should be in original containers and put in a Ziploc bag with their name clearly marked on it.