

Emergency Contact and Medical Information

Child (Last Name, First Name)	Date of Birth	M	F
		Sex	
Parent's/Guardian's Name	Parent's/Guardian's Name		
()	()		
Home Phone	Work Phone	Home Phone	Work Phone
()	()	()	()
Cell Phone	Cell Phone		
Address	Address		

Alternate Emergency Contacts

Primary Emergency Contact	Secondary Emergency Contact		
()	()		
Home Phone	Work Phone	Home Phone	Work Phone
()	()	()	()
Cell Phone	Cell Phone		
Address	Address		
City, ST ZIP Code	City, ST ZIP Code		

Medical Information

Physician's Name	Phone Number
Insurance Company	Policy Number

I consent to and authorize the Marching Band Camp staff to evaluate, examine, and treat the participant as appropriate under the circumstances for injuries or illnesses that may occur, including permission for physical examination, administration of medications and injections, and emergency medical transport. I also authorize the staff to disclose to, and receive from, any physician, hospital, or health care provider any health information immediately relevant to an urgent or emergent medical condition.

Parent's/Guardian's Signature	Date
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Last Name _____ First Name _____
Date of Birth _____

Student Medical Information

Allergies: (Please list all known)

Medication allergies: _____ Reaction: _____

Food Allergies: _____ Reaction: _____

Other Allergies (include insect stings, hay fever, etc.) _____
Reaction: _____

General Questions: (Please explain 'yes' answers)

Has the participant:	Yes	No	Please explain
1. Had any recent injury, illness or infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Have a chronic illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Ever have a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Ever have a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Have skin problems (itching, rash, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Have asthma or lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Have any bleeding problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Have any orthopedic problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Have ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Use this space to provide any additional information about the participant:

