Marysville Bands Emergency Contact and Medical Information

Child's 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

Address

Address

City, ST ZIP Code

City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact

Secondary Emergency Contact

( )
Home Phone

( )
Work Phone

( )
Home Phone

( )
Work Phone

Address

Address

City, ST ZIP Code

City, ST ZIP Code

Medical Information

Medical issues/concerns the chaperones need to be aware of

Physician's Name

Phone Number

Insurance Company-PLEASE ATTACH COPY OF CARD-BOTH SIDES

Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature

Date

I give permission for my child to participate in Marysville Band activities. I release Band Booster members and chaperones from liability in the case of an accident during activities related to Marysville Bands.

Parent's/Guardian's Signature

Date

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Health History

Check any of the following that you have had or currently have:

	Sinus Trouble		Asthma		Fainting Spells
	Rheumatic Fever		Diabetes		Earache/Ear Infection
	Kidney Disease		Heart Trouble		Frequent Diarrhea
	Epilepsy		Tuberculosis		Severe Stomach Pain
	Hay Fever		Menstrual Problems		Stinging Insect Reaction

Other Allergies/Reactions to Medicine - - What Medicine do you take to treat these reactions?

Please Provide the Following Information.....

Yes	No	Do you tire easily?
Yes	No	Do you get out of breath easily?
Yes	No	Have you had more than a brief, minor illness or injury in the past year?
Yes	No	Do you have any condition now requiring regular medication or treatment?
Yes	No	Have you had any surgeries or serious injuries? If yes, specify and show dates.
Yes	No	Are you currently taking medication prescribed by a doctor?
Yes	No	Are there any special health considerations?

Please provide any additional information for the questions above that were answered yes.

Date of last tetanus shot_____

MUST ATTACH COPY OF CURRENT IMMUNIZATION RECORD

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