

THE COLTS DRUM AND BUGLE CORPS - MEDICAL AND RELEASE FORM

Name _____ Birthdate ____ / ____ / ____
 Home Address _____
 City _____ State _____ Zip _____
 Parent's Home Phone (____) ____ - _____ Member's Social Security Number _____ - ____ - _____

Physician Name _____ Office Phone (____) ____ - _____
 Clinic or hospital name _____ Address _____
 City _____ State _____ Zip _____
 Parents: Father's Name _____ Mother's Name _____
 Work Phone (____) ____ - _____ Work Phone (____) ____ - _____
 Cell Phone (____) ____ - _____ Cell Phone (____) ____ - _____
 Name of other adults to contact in case of emergency if parents cannot be reached:
 Name _____ (or) Name _____
 Home Phone (____) ____ - _____ Home Phone (____) ____ - _____
 Work Phone (____) ____ - _____ Work Phone (____) ____ - _____
 Cell Phone (____) ____ - _____ Cell Phone (____) ____ - _____

Medicine allergies and use: Place an "X" in the proper column to indicate which medications you use or are allergic to:

(Use)	(Allergy)	(Use)	(Allergy)
_____	_____ aspirin	_____	_____ demerol
_____	_____ penicillin	_____	_____ antibiotics
_____	_____ sulfa	_____	_____ sedatives
_____	_____ codeine	_____	_____ other _____

History of Treatments: Please describe medical attention given to the member during the past two years, and describe the illness, treatment or injury. (Please attach additional information if necessary for full disclosure)

<u>Date</u>	<u>Illness, symptom, injury</u>	<u>Treatment</u>
-------------	---------------------------------	------------------

Insurance:

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 (____) ____ - _____
 Member is insured under: _____ Father's Policy _____ Mother's Policy
 _____ Own Policy _____ Other (explain: _____)

Medications:

Are you currently taking any prescription medications on a regular basis? _____ Yes _____ No

If yes, answer the following:

<u>Medication</u>	<u>Dosage</u>	<u>When taken</u>	<u>For</u>
_____	_____	_____	_____
_____	_____	_____	_____

Date of last tetanus shot ____ / ____ / ____
 Do you wear glasses? _____ Yes _____ No Contacts? _____ Yes _____ No
 Do you smoke cigarettes? _____ Yes _____ No

Medical History:

Place an "X" next to any of these illnesses you have had or are prone to have:

- | | | |
|----------------------|---------------------|--------------------------|
| _____ Eczema | _____ Measles | _____ Rheumatic fever |
| _____ Hives | _____ Mononucleosis | _____ Nervous exhaustion |
| _____ Bronchitis | _____ Mumps | _____ Tonsillitis |
| _____ Diverticulitis | _____ Chicken Pox | _____ Epilepsy |
| _____ Hemorrhoids | _____ Polio | _____ Diabetes |
| _____ Hernia | _____ Hepatitis | _____ Asthma |

(Be certain to complete both sides!)

