COLTS DRUM & BUGLE CORPS **MEDICAL AND RELEASE FORM**

Name ____ Birthdate ____/____/_____
Home Address ____________________________________ Email ______________________
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)	(Allergic)		(Use)	(Allergic)	
_____	_____	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.)

Date *Illness / Symptom / Injury* *Treatment*

____

____

****

Insurance: Company Name ______________________________ Policy # ________________________________
Company Address ______________________________________ Phone (______) ________ - _______________
City ____ State ________ Zip __________
Agent's Name; Or name of Employer for group policy ____
Agent's Phone; Or Employer's Benefits Office Phone (_______) ________ - _______________
Member is insured under: _____ Father's Policy _____Mother's Policy Policy Holder's Birthdate ______/______/_______
_____Own Policy _____ Other (explain:____)

****

Medications:
Are you currently taking any prescription medications on a regular basis? _____ Yes ______ No
If yes, answer the following:

Medication	*Dosage*	*When taken*	*For*
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

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:

_____ Asthma	_____ Eczema	_____ Hives	_____ Nervous Exhaustion
_____ Bronchitis	_____ Epilepsy	_____ Measles	_____ Polio
_____ Chicken Pox	_____ Hemorrhoids	_____ Mononucleosis	_____ Rheumatic Fever
_____ Diabetes	_____ Hepatitis	_____ Mumps	_____ Tonsillitis
_____ Diverticulitus	_____ Hernia		

<< Be certain to complete both sides! >>

Any other serious illnesses or operations you have had:

____
____
____
____

****

Place an "X" next to any of these you have had, or may be prone to have, either *sometimes or frequently*:

Nose and Throat:

_____ congested nose
_____ runny nose
_____ sneezing spells
_____ head colds
_____ nose bleeds
_____ sore throat
_____ enlarged tonsils
_____ hoarse throat
_____ bee sting allergy

Mouth:

_____ dental problems
_____ itching or burning
_____ sore tongue
_____ taste changes

Skin:

_____ acne
_____ itching and bleeding
_____ bleeds easily
_____ bruises easily
_____ sunburns easily

Head and Neck:

_____ frequent headaches
_____ neck pains and swelling

Respiratory:

_____ wheezes
_____ coughing spells
_____ coughs up blood
_____ excessive swelling
_____ inadequate sweating
_____ sun "poisoning"

Cardiovascular:

_____ high blood pressure
_____ racing heart
_____ chest pains
_____ dizzy spells
_____ shortness of breath
_____ swollen feet or ankles
_____ leg cramps

Musculoskeletal:

_____ aching muscles or swollen joints
_____ swollen joints

****

Consent

I acknowledge that ______________________________________ (name of son or daughter) is a member of the Colts Drum & Bugle Corps, and as a member, engages in practices, tour, travel and performances. I, the undersigned parent or guardian, desires that said member receive the proper medical treatment in the event of illness or accident. I as said parent or guardian consents to the administration of all medical treatments as is deemed necessary, and accept financial responsibility for said treatments. In accepting this consent, the Colts agree to notify me in a reasonable amount of time in the event of any serious accident or illness.

______________________ ____ / ____ / ____ ______________________ ____ / ____ / ____
Parent or Guardian *Date* *Witness* *Date*

TO THE HOSPITAL:

In case of emergency, I as parent or guardian, authorize the attending Colts staff member to sign release and consent forms for admitting and treatment of:

_________________________________(name of son or daughter)

______________________ ____ / ____ / ____ ______________________ ____ / ____ / ____
Parent or Guardian *Date* *Witness* *Date*

TO THE HOSPITAL AND SURGEON:

If emergency surgery is required, and I cannot be reached, I authorize the attending Colts staff member to sign proper release, admittance and consent forms for surgery and related treatment of:

_________________________________(name of son or daughter)

______________________ ____ / ____ / ____ ______________________ ____ / ____ / ____
Parent or Guardian *Date* *Witness* *Date*

<< Be certain to complete both sides! >>