COLTS DRUM & BUGLE CORPS MEDICAL HISTORY FORM

Members must submit a copy of insurance card, physical, and immunization record along with this form.

Student Name_____ Sex_____ Section_____

Student Cell Phone_____ Birthdate_____

Address_____ City, State, Zip_____

Please answer **all** questions by circling "YES" or "NO". Explain "YES" answers in the area below.

1.	Have you had any medical problem or injury since your last physical?……	YES	NO
2.	Have you ever been hospitalized?……..	YES	NO
3.	Have you ever had surgery?……..	YES	NO
4.	Are you taking any medications, pills, vitamins, minerals, supplements, herbal treatments, or energy/enhancing drinks/powders/pills/shots/foods?…….....	YES	NO
5.	Have you ever passed out during exercise?……...	YES	NO
6.	Have you ever had shortness of breath after exercise?……..	YES	NO
7.	Have you ever had chest pain during or after exercise?……	YES	NO
8.	Have you ever been dizzy during a workout?……	YES	NO
9.	Do you have high or low blood pressure?…….	YES	NO
10.	Do you have any skin problems (itching, rashes, acne)?……...	YES	NO
11.	Have you ever had a head injury, been knocked out or unconscious?……..…..	YES	NO
12.	Have you ever had a seizure?……	YES	NO
13.	Have you ever had a stinger, burner, or pinched nerve?……	YES	NO
14.	Have you ever had heat or muscle cramps?……...	YES	NO
15.	Have you ever been dizzy or passed out because of the heat?……...	YES	NO
16.	Have you ever had trouble breathing or do you cough during or after activity?……...	YES	NO
17.	Have you ever had problems with your vision or eyes?……	YES	NO
18.	Do you wear glasses, contacts, or protective eyewear?…….	YES	NO
19.	Have you ever sprained, strained, dislocated, fractures, broken, or had repeated swelling or other injuries of any body parts?…..……*(Please Circle)*…….. Head Shoulder Thigh Neck Elbow Knee Chest Forearm Back Shin/Calf Wrist Ankle Hip Hand Finger(s) Abdominal Other	YES	NO
20.	Have you ever had any other medical problems (mononucleosis, diabetes, etc.)?……	YES	NO
21.	Are you currently under the care of a physician?…….. IF YES Explain here:_____ _____	YES	NO
22.	Do you use prescription medication?...*(If yes, Please list prescription medications)*... Medication(s): _____	YES	NO
23.	When was your last menstrual period?…….. _____		
24.	What was the longest time between periods in the past year?..... _____		

25. 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	_____

Please list other medications you USE here – please be specific: _____

_____

Please list other medications you are ALLERGIC TO here – please be specific: _____

_____

PLEASE EXPLAIN ANY "YES" ANSWERS BELOW (feel free to attach a sheet as necessary):

_____

_____

_____

_____

MEAL PLAN/FOOD ALLERGIES – We offer two meal options (Standard and Vegetarian), and are sensitive to individual allergies. We do not offer a vegan meal option as we cannot sustain the nutritional demands of tour with this dietary choice.

Please check here if you desire a vegetarian meal plan on tour: _____

Please list any food allergies here: _____

COLTS DRUM & BUGLE CORPS INSURANCE FORM

PLEASE COMPLETE AND RETURN TO 1101 Central Avenue, Dubuque, IA 52001; Fax 563-582-7317

Student Name_____ Sex_____ Section_____
Student Cell Phone_____ Birthdate_____
Address_____ City, State, Zip_____

*Father/Guardian Emergency Name*_____
Address _____
City/State/Zip _____
Employer's Name _____
Employer's Address_____
Cell Phone_____
Date of Birth _____

*Mother/Guardian Name*_____
Address _____
City/State/Zip _____
Employer's Name_____
Employer's Address_____
Cell Phone_____
Date of Birth_____

Medical Insurance
Policyholder Name_____ Insurance Name_____
Policy/Plan Number _____ Group Number _____
Insurance Phone_____ Is this a HMO or PPO? _____if so, which one? _____
Second opinion for surgery required? (Y/N)_____ Primary Physician name _____ Phone _____
Emergency Room Preferred by insurance in Dubuque FINLEY, MERCY or EITHER_____
Insurance website address: _____
Authorization from insurance required before seeing specialist? (Y/N) _____
Please list specialty physicians below your insurance allows you to see in Dubuque (list practice name if all doctors apply):
Family Practitioner_____ Ophthalmology_____ Pulmonology_____
Orthopedic _____ Neurologist_____ Dental _____
Pharmacy _____ Ear, Nose, Throat _____Cardiologist_____
If there are no physicians for any of the above areas in Dubuque covered by your insurance please list procedures to be taken if the above specialist are needed. For example - "Contact emergency room," "Call parents" _____

Consents:

I hereby authorize the Colts Drum & Bugle Corps to inspect or secure copies of all medical records and any data relating to injury. A photocopy of this authorization shall be deemed as effective and valid as the original. I certify that the answers provided are true, complete, and correct to the best of my knowledge. **Please notify the Colts Drum & Bugle Corps of any changes immediately.**

_____ _____ _____ _____
Parent or Guardian Date Witness Date

I acknowledge that _____ (name of child) participates with the Colts Drum & Bugle Corps, and as a member engages in practices, tour, travel, and performances. I, the undersigned parent or guardian, desires said member to receive the proper medical treatment in the event of illness or accident. I, as said parent or guardian, consent 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:

_____ _____ _____ _____
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:

_____ _____ _____ _____
Parent or Guardian Date Witness Date