

# COLTS DRUM & BUGLE CORPS MEDICAL HISTORY FORM

*Contracted members must also submit a copy of insurance card, physical, and immunization record.*

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 prescriptions or medications?..... YES NO
5. Are you taking any other pills, vitamins, minerals, supplements, herbal treatments, or energy/enhancing drinks/powders/pills/shots/foods?..... YES NO
6. Have you ever passed out during exercise?..... YES NO
7. Have you ever had shortness of breath after exercise?..... YES NO
8. Have you ever had chest pain during or after exercise?..... YES NO
9. Have you ever been dizzy during a workout?..... YES NO
10. Do you have high or low blood pressure?..... YES NO
11. Do you have any skin problems (itching, rashes, acne)?..... YES NO
12. Have you ever had a head injury, been knocked out or unconscious?..... YES NO
13. Have you ever had a seizure?..... YES NO
14. Have you ever had a stinger, burner, or pinched nerve?..... YES NO
15. Have you ever had heat or muscle cramps?..... YES NO
16. Have you ever had or been diagnosed with a heat related illness?..... 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
20. Have you ever had any other medical problems (mononucleosis, diabetes, seizures, asthma, etc.)? Please list:\_\_\_\_\_ YES NO
21. Are you currently under the care of a physician?..... YES NO  
 IF YES Explain here:\_\_\_\_\_
22. Do you use prescription medication?...*(If yes, Please list prescription medications)*... YES NO  
 Prescription(s):  
 \_\_\_\_\_  
 \_\_\_\_\_
23. Have you ever been diagnosed with or suffered from a psychological or psychiatric concern? (Please note any yes answer below) YES NO
24. If Female: Do you have menstrual periods? What was the longest time between periods in the past year, and are they regular? Time\_\_\_\_\_; Regular?..... YES NO
25. Have you been tested for sickle cell anemia or sickle cell trait? YES NO  
 If Yes, have you been diagnosed with sickle cell anemia or sickle cell trait? YES NO
26. Medicine allergies: Please list other medications you are ALLERGIC TO here – please be specific:  
 \_\_\_\_\_  
 \_\_\_\_\_

27. Other allergies: Please list any other allergies here:  
 \_\_\_\_\_

28. Please list other medications you USE here – please be specific:  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE EXPLAIN ANY "YES" ANSWERS (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 or sensitivities here (even if noted above, including dairy, soy, gluten, etc):**  
 \_\_\_\_\_

# COLTS DRUM & BUGLE CORPS INSURANCE FORM

PLEASE COMPLETE AND RETURN TO 2300 Twin Valley Drive, Dubuque, IA 52003; [colts@colts.org](mailto:colts@colts.org); or Fax 844-347-5323

Student Name \_\_\_\_\_ Sex \_\_\_\_\_ Section \_\_\_\_\_  
Student Cell Phone \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**Father/Guardian Name** \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Email \_\_\_\_\_

**Mother/Guardian Name** \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Email \_\_\_\_\_

## **Medical Insurance**

Policyholder Name \_\_\_\_\_ Insurance Name \_\_\_\_\_  
Policy/Plan Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Insurance Phone \_\_\_\_\_ Is this a (please circle): HMO PPO Other: \_\_\_\_\_  
Second opinion for surgery required? (Y/N) \_\_\_\_\_ Primary Physician name \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance website address: \_\_\_\_\_

Authorization from insurance required before seeing specialist? (Y/N) \_\_\_\_\_

## **Please list specialty physicians below your insurance allows you to see:**

Family Practitioner \_\_\_\_\_ Ophthalmology \_\_\_\_\_ Pulmonology \_\_\_\_\_  
Orthopedic \_\_\_\_\_ Neurologist \_\_\_\_\_ Dental \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Ear, Nose, Throat \_\_\_\_\_ Cardiologist \_\_\_\_\_

**Please list procedures to be taken if a specialist is needed:** \_\_\_\_\_

## **Consents (Parent signature required if student is 17 years of age or younger):**

### **PERMISSION FOR MEDICAL INFORMATION:**

I hereby authorize the Colts Youth Organization 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 of any changes immediately.**

\_\_\_\_\_  
Signature Date Witness Date

### **PERMISSION TO PARTICIPATE AND PROVIDE CARE:**

I acknowledge that \_\_\_\_\_ (name of student) has permission to participate with the Colts Youth Organization, and has permission to engage in practices, tour, travel, and performances. I, the undersigned, desires said student to receive proper medical treatment in the event of illness or accident. I consent to the administration of all medical treatments as deemed necessary, and accept financial responsibility for 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.

\_\_\_\_\_  
Signature Date Witness Date

### **PERMISSION TO USE INSURANCE:**

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

\_\_\_\_\_  
Signature Date Witness Date

### **PERMISSION TO THE CLINIC, HOSPITAL, OR HEALTH CARE PROVIDER:**

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

\_\_\_\_\_  
Signature Date Witness Date