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	YES	NO
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?…….. IF YES Explain here:_____	YES	NO
22.	Do you use prescription medication?...*(If yes, Please list prescription medications)*... Prescription(s): _____ _____	YES	NO
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 YES	NO NO
25.	Have you been tested for sickle cell anemia or sickle cell trait? If Yes, have you been diagnosed with sickle cell anemia or sickle cell trait?	YES YES	NO 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 colts@colts.org; 2300 Twin Valley Drive, Dubuque, IA 52003; 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)*:

ACCESS OF MEDICAL INFORMATION:
I hereby authorize the Colts Youth Organization to inspect or secure copies of medical records and/or any data relating to injury or illness. 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

PARTICIPATION AND CARE:
I consent that the above named 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 and communication of any medical treatments 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