Scottsboro High School Band Medical Form

Participant Name:_____ Date of Birth: _ _ /_ _ / _ _ _ _
(Last, First) (Month, Date, Year)

Participant Address:_____ Soc. Sec. # _ _ _ - _ _ - _ _ _ _
_____ Home Phone: _ _ _ - _ _ _ - _ _ _ _

Participant's Local Physician:_____
Physician's Phone Number: _ _ _ - _ _ _ - _ _ _ _
Past Medical History: _____
_____
Last Tetanus Booster: _ _ / _ _ / _ _ _ _
Allergies: _____
Physical Limitations or use of adaptive equipment? ___ no ___ yes
If yes please describe :
_____
Prescription Medications: ___ no ___ yes, please list _____
_____
Is the participant responsible for taking their own medications? ___ no ___ yes (Please provide name of person who is to medicate participant:
_____
Participant Insurance Information:
Company Name: _____
Address: _____
_____
Customer Service Number: _____
Policy Number: _____ Group ID: _____
Name of Insured: _____ Relationship to participant: _____

Please provide primary and secondary emergency notification information

1. Parent or Guardian_____ Address:_____ _____ Phone: Day ___-___-____ Night ___-___-____ Cell ___-___-____	2. Emergency Contact:_____ Relationship to participant:_____ Phone: Day ___-___-____ Night ___-___-____ Cell ___-___-____

Permission for Medical Treatment:

I, the undersigned being of legal authority for the participant enlisted above, hereby authorize representatives of the Scottsboro High School Band to provide information and secure medical treatment to the participant listed on this form.

_____ Date:_____
(Signature)

_____ Notary Seal:
(Printed Name)

_____ My Commission Expires:
(Notary Signature)