

Wakefield High School Warrior Marching Band

Medical Form 2010

Please print or type in the following information:

Name: _____ D.O.B.: _____ Age: _____ Sex: _____

Parent / Guardian: _____ Tel.# _____.

Home Address: _____ Other Ph.# _____.

Family Physician _____ Tel. # _____.

Health Insurance Co.: _____ Policy # _____.

In case of an emergency, if parent can't be contacted, please notify:

Name: _____ Relationship: _____.

Address: _____ Tel.# _____.

ALLERGIC REACTIONS

Bee Sting _____ Penicillin _____ Drugs (List) _____.

Other: _____.

Are there any illnesses for which this child is currently receiving treatment and / or medication ?
Yes / No Please list and describe medications:

In Case of medical emergency, I hereby authorize any licensed physician, hospital, clinic, or other medical facility to hospitalize and secure proper treatment for my child as named above. In the event that a parent / guardian or contact person cannot be reached by telephone, I authorize my child's director or chaperone to secure emergency treatment for my child.

Signature of parent or guardian

Date