Wakefield HS Warrior Marching Band- **Medical Form 2015**

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:

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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.

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 Signature of parent or guardian Date