

Wakefield Warrior Marching -Medical Form 2016

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

Parent / Guardian: _____ Tel.# _____

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Home Address: _____ Other Ph.# _____

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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.

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Signature of parent or guardian

Date