Wakefield Warrior Marching -**Medical Form 2017**

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