

MEDICAL HISTORY

Please check all that apply.

___ Allergies (Please List) _____
___ Migraine (Please List Treatment) _____
___ Epilepsy (Please List Treatment) _____
___ Back Injury (Please List Treatment) _____
___ Other (Please Specify) _____
 (Please List Treatment) _____
___ Food Allergies: _____

Are there ANY medical conditions which could affect Band/Colorguard participation?

If yes, please describe _____

All medications must be registered on this form. Please list any and all medications used by the student _____

Medical Insurance Carrier _____
Policy _____ Telephone _____

Please Include Copy of Insurance Card!

I have read and understand all of the above requirements. I further understand and agree that the above information will become part of a student file. I certify that the above information is correct, and I agree to notify the Band Office immediately should any changes to this information occur.

Signature of Parent or Guardian

Date

Telephone