TREATMENT AUTHORIZATION and MEDICAL INFORMATION

Name	Birthdate
Home Address	Phone
	Cell Phone

Parent/Guardian Information

Mother/Guardian Name	Father/Guardian Name
Home Phone	Home Phone
Cell Phone	Cell Phone
Work Phone	Work Phone

Alternate Contact – *Person to notify in case of emergency if parents/guardians are not available*

Alternate Contact Name	Phone	Relationship

Physician

Physician's Name	Phone	Fax
Physician's Office Address		

Vaccinations/Immunizations

Year of last Tetanus Shot:		Have you been vaccinated for:	Measles? Yes No
If it has been more than 5 years, we suggest that you get a booster shot.		Chicken Pox? Yes No	Hepatitis? Yes No

MEDICAL INFORMATION

Any reaction to penicillin? Yes No	Any reaction to any other drugs? Yes No	Any regular use of medication? Yes No	Any use of insulin? Yes No
Any chronic physical problems? Yes No	Any known allergies (food/medicine)? Yes No	Any dietary restrictions? Yes No	

Special Medical Problems – *Indicate all that apply*

Diabetes Asthma Heart Conditions Hypoglycemia Arthritis

Seizures Mono High Blood Pressure Rheumatic Fever TB Breathing Disorders Migraine Headaches

Carpal Tunnel Syndrome Back Problems Bleeding Disorder Wear Glasses/Contacts

Knee/Ankle Injuries | Fractures/Surgeries (indicate location)

Please explain if you answered "Yes" or indicated that any of the special medical problems above apply:

Non-Prescription Medication – *Indicate those Over-the-Counter Medications you **DO NOT** give permission for staff to administer*

Aspirin Tylenol Advil Ibuprofen Antacids Cough Cold & Sinus Cold & Flu Antidiarrheal

Allergic Reaction Laxative Topical Ointments, Creams, or Lotions

If you have a preference or special need for a specific Over-the-Counter medication, it is your responsibility to supply the corps with that medication.

TREATMENT AUTHORIZATION and MEDICAL INFORMATION – page 2

Name	Birthdate
Home Address	Phone
	Cell Phone

PRESCRIPTION MEDICATION – *Please attach a Doctor's Note if necessary*

My child/ward has my permission to take the following MEDICATION **as prescribed** by our family doctor. We understand that should our child/ward be found in possession of any prescription drug not specified herein, disciplinary action may be taken.

Prescription medications are required to be given to the medical volunteers to dispense if the member is under the age of 18.

Name of Medication	Condition for Medication	Time/Frequency	Dosage

INSURANCE INFORMATION – *Please attach a copy of your MEDICAL INSURANCE CARD*

Medical Insurance Company	Phone	Fax
Insurance Company Address		
Subscriber Name	SS#	Birthdate
Subscriber's Employer	Phone	Group/ID#
Employer Address		

MEDICAL HISTORY

The medical history provided on these pages is accurate and current to the best of my knowledge.

I authorize the Troopers Drum & Bugle Corps to seek medical evaluation and treatment of injury or illness as deemed necessary by a designated adult representative of the organization.

In the event that the member listed herein becomes incapacitated or a parent/guardian cannot be reached in an emergency, I hereby give permission to the physician, selected by a designated adult representative of the Troopers Drum & Bugle Corps, to hospitalize, secure proper anesthesia, or give any other necessary care. This authorization does not cover major surgery unless prior to surgery, the medical opinions of two other physicians concur in the necessity for such surgery.

Date	Date
Signature of Participant	Signature of Parent/Guardian (required if participant is under 18 years of age)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Troopers Drum & Bugle Corps to release to physicians, medical, or dental practitioners, hospitals, clinics, or other health care providers and insurance companies, all pertinent information concerning the evaluation, treatment, and payment for the member listed herein.

Any and all information provided to the Troopers will be kept strictly confidential unless it is required or necessary for medical treatment.

I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for benefits has been submitted. I have a right to receive a copy of this authorization upon request. A photocopy of this form is as valid as the original.

Date	Date
Signature of Participant	Signature of Parent/Guardian (required if participant is under 18 years of age)