Wakefield Warrior Marching Band -**Medical Form 2024**

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