

# Wakefield Warrior Marching Band -Medical Form 2026

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_

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