



**ADULT Emergency Information Form  
Winter 2011-2012**

**Permission for Emergency Treatment**

Please return this form to any SCACMB Director or mail to:

St. Cloud All-City Marching Band

PO Box 7762

St. Cloud, MN 56302-7762

(PLEASE PRINT/USE BLACK OR BLUE INK ONLY)

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Name of Health Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Does your insurance company have any special requirements you want us to know about? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are you on any medication (continuous or intermittent)? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please explain. \_\_\_\_\_

Is there any past medical history we need to be aware of (surgical, hospitalization, serious chronic illness?)

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain \_\_\_\_\_

(PLEASE CONTINUE ON BACK SIDE)

PARENT NAME: \_\_\_\_\_

Do any of the following conditions pertain to you?

Diabetic Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Asthmatic Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Fainting Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Hyperventilating Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Sleepwalking Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Diet Restrictions Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Do you have any medication allergies or food allergies?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

Date of Last Tetanus Immunization: \_\_\_\_\_

Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

**PERMISSION FOR MEDICAL TREATMENT**

I give permission for the Band Chaperones or Band Directors to authorize necessary medical treatment for myself, should a medical emergency arise.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

Date: \_\_\_\_\_