



ADULT Emergency Information Form Summer 2009

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 _____

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: _____