CYO Emerald Knights
Band and Guard of Kenosha and Racine

# MEDICAL INFORMATION

***Please sign and return before first rehearsal!***

**Office Use Only:**
Date Received: _____
☐ Allergies _____
☐ Medical Condition _____
☐ Medication _____
☐ Dietary Restrictions _____
☐ Activity Restrictions _____

For our records and for your protection, please complete this form, supplying **ALL** requested information. This form requires your signature. **PLEASE USE INK AND PRINT CLEARLY.**

**Last Name:** _____
**First Name:** _____
Date of Birth (MMDDYY): ____ /____ /____
Address: _____ City: _____ Zip: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____

**MEDICAL HISTORY** It is recommended that all adult volunteers/chaperones/staff have had a physical examination within the past 3 years.

Have you had a Physical Exam in the past 3 years: **___ Yes ___ No** Approximate date of your last **Tetanus (DTP)** booster: _____ Month/Year

**Past Serious Illness / Injury or Surgeries / Hospitalizations:** Please indicate the following

| **Dates:** | **Details:** |
|---|---|
| | |
| | |

**Current Health Concerns:** Please check any pre-existing health conditions

☐ Allergies
- ☐ Animals/Insects
- ☐ Foods: _____
- ☐ Plants/Hay Fever
- ☐ Medication _____

☐ Asthma
☐ Diabetes
☐ Emotional Problems

☐ Eye Glasses
☐ Hearing Aides
☐ Headaches

☐ Heart Problems
☐ Joint Problems / Arthritis
- ☐ Back problems
- ☐ Knee/ankles problems

☐ Seizure Disorder
☐ Other (Please specify) _____

**For any Health Concerns or Allergies** listed above, please describe the management of and care that would be needed:

_____

**Do you require any special dietary considerations?** ___ Yes ___ No
Please explain: _____

**Are there any limitations on the amount/type of physical activities that you can be participated in?** ___ Yes ___ No
Please explain: _____

**Medications** taken routinely Reason for taking

| | |
|---|---|
| | |
| | |
| | |

**TREATMENT AUTHORIZATION -** In the event that you would need medical treatment, please list those to be contacted.

| Name | Relationship | Phone |
|---|---|---|
| 1. | | ( ) |
| 2. | | ( ) |

| **Medical Insurance** Carrier or Plan Name | | **Policy/Group #** | | * * If you have a Medical Insurance Card or Form, please provide a copy. |
|---|---|---|---|---|

**CONSENT FOR TREATMENT** - If a situation occurs in which you would require immediate medical attention, this signed statement will serve as authorization for the C.Y.O Band & Guard or any of its agents to provide, obtain or authorize any reasonable incidental and/or emergency medical treatment in the event of the illness, injury or incapacity.

_____
Signature Date

**ACCURACY** - This health history is correct and complete as far as I know,

Signature Date

CYO Emerald Knights Band and Guard
2401 69th Street • Kenosha, WI 53143 • Phone 262.656.1610 • cyomusic@gmail.com • www.cyoband.org