

**Midland Valley Bands**  
**Medical Information**

Student Name \_\_\_\_\_ Mailing Address \_\_\_\_\_

Phone # \_\_\_\_\_ D.O.B \_\_\_\_\_ SSN \_\_\_\_\_

Name(s) of Parent(s) or Guardian(s) \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

NAME

PHONE

Does Participant have medical insurance? YES \_\_\_\_\_ NO \_\_\_\_\_

Insurance Company & Policy Number:

\_\_\_\_\_

Health History: (check all that apply)

Please list any allergies your child has below.

- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Orthopedic Problems
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Epilepsy
- \_\_\_\_\_ Cardiac Problems
- \_\_\_\_\_ Other (specify on back)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do we have permission to administer to your child over-the-counter medications for maladies including, but not limited to: headache, body pain, fever, nausea, gastric illness, cuts, bruises, eye injuries, etc....

YES \_\_\_\_\_ NO \_\_\_\_\_

Please list any over-the-counter medications your child CAN NOT have.

\_\_\_\_\_  
\_\_\_\_\_

Has your child had a tetanus shot current to within six (6) years?

YES \_\_\_\_\_ NO \_\_\_\_\_

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? If yes, please explain below (attach additional sheet if needed).

\_\_\_\_\_  
\_\_\_\_\_

In the event of an emergency, I give permission to a licensed physician or hospital to secure proper treatment for and to order medications, injections, anesthesia and/or surgery for my child as named above.

Signature of Parent or Guardian

Date