# MAVERICK MARCHING BAND MEDICAL INFORMATION FORM

***

FULL NAME _____ Section _____
(First) (Middle) (Last)

DATE OF BIRTH _____ NUID _____

SEX: Female Intersex Male Prefer Not to Answer

PERMANENT ADDRESS _____
(Number) (Street) (Apt. #) (City/State) (Zip)

LOCAL ADDRESS _____
(Number) (Street/Dorm) (Apt. #) (City/State) (Zip)

**IN CASE OF EMERGENCY NOTIFY:**

1) NAME _____ PHONE: _____
(Area Code)

RELATION _____ ADDRESS _____
(Number) (Street) (City) (Zip)

2) NAME _____ PHONE: _____
(Area Code)

RELATION _____ ADDRESS _____
(Number) (Street) (City) (Zip)

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PRIMARY PHYSICIAN _____ PHONE _____

PRIMARY DENTIST _____ PHONE _____

ALLERGIES/DIETARY RESTRICTIONS

_____

_____

_____

(over)

MEDICATIONS CURRENTLY TAKEN

_____

DATE OF LAST TETANUS SHOT _____ DATE OF LAST PHYSICAL _____

LIST ANY SIGNIFICANT MEDICAL HISTORY BELOW (I.E. ASTHMA, SEIZURES, DIABETIC)

_____

_____

_____

LIST PREVIOUS SURGERIES_____

DO YOU WEAR CONTACTS OR DENTAL APPLIANCES? _____ WHAT KIND? _____

HAVE YOU EVER BEEN MEDICALLY LIMITED OR DISQUALIFIED FROM SPORTS ACTIVITIES? _____

IF SO, WHY? _____

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**INSURANCE INFORMATION**

NAME OF HEALTH CARE PROVIDER/PPO _____

ADDRESS _____
(Number) (Street) (City/State) (Zip)

PHONE _____ GROUP NO. _____

INDIVIDUAL NO. _____ EFFECTIVE DATE _____

POLICY HOLDER'S NAME _____

***This information is confidential and will only be used in case of emergency.***