THE MUCHACHOS INC. MEDICAL FORM

IF MEMBER IS UNDER 18 YEARS OF AGE, THIS FORM IS TO BE FILLED OUT BY A PARENT/GUARDIAN. PLEASE PRINT.

LAST NAME:			FIRST NAME:		HOME PHONE:
DATE OF BIRTH: / /	AGE		MALE	FEMALE	CELL PHONE:
HOME ADDRESS:					**Essential Eligibility Requirements: Ability for extended periods of physical activity, possibly in the sun or extreme temperatures.**
CITY:			STATE:	ZIP CODE:	
PARENT/GUARDIAN (If under 18 years of age):			WORK PHONE:		CELL PHONE:
ALTERNATE EMERGENCY CONTACT:			RELATIONSHIP:		PHONE NUMBER:
MEDICAL INSURANCE CARRIER:			POLICY/GROUP NO.		INSURED PERSON:
INSURANCE CO. ADDRESS:					INSURANCE CO. PHONE NUMBER:

IMPORTANT: PLEASE PROVIDE A COPY OF MEDICAL INSURANCE CARD - FRONT & BACK.

		If Yes – Please Explain:
Ear Infections	Y N	
Heart Defect/Disease	Y N	
Hypertension	Y N	
Mononucleosis	Y N	
Seizures	Y N	
Diabetes	Y N	
Bleeding or Clotting	Y N	
Bed Wetting	Y N	
ADD/ADHD	Y N	
Asthma	Y N	
Digestive Disorders	Y N	
Physical Limitations	Y N	

If additional space is required for explanations, please use reverse side.

DATE OF LAST TETANUS:

DATE OF LAST PHYSICAL:

Failure to disclose medical information may lead to immediate dismissal from the corps. It is your obligation to notify us of any changes in the following:

Current health conditions requiring medical attention: Under Doctor's care? Y N

Medical equipment or device needed? (i.e. insulin pump, nebulizer) Y N
Emergency medication needed? Y N
Recent hospitalizations or operations? Y N
Serious illnesses? Y N
Diabetes? Y N
Dietary restrictions? (describe) Y N

Physician: Phone:

Are there any behavioral issues that may impact participation? Y N

Any other factors that may affect the care of the corps member? Y N

Non Prescription Medications		ALLERGIES	
I authorize the following medications or their generic equivalent to be administered if needed:		Hay Fever	Y N
		Bee Stings	Y N
		Oak/Ivy	Y N
Liquid Benadryl	Y N	Penicillin	Y N
Throat Lozenges	Y N	Other Drugs	Y N
Hydrocortisone Cream	Y N	Food – Please Specify:	
Antibiotic Cream	Y N		
Tylenol	Y N		
Ibuprofen	Y N	Other – Please Specify:	
Pepto-Bismol	Y N		
Chloroseptic	Y N		
Antacids	Y N		

MEDICATION DISTRIBUTION

Current medications:

Name of Medication	Reason for Medication	When is it taken?

AUTHORIZATION FOR TREATMENT: THE INFORMATION PROVIDED IS CORRECT SO FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CORPS ACTIVITIES. IN CASE OF MEDICAL EMERGENCY, I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE MUCHACHOS DRUM & BUGLE CORPS, TO ORDER X-RAYS, ROUTINE TESTS, TREATMENT, AND NECESSARY TRANSPORTATION FOR ABOVE SPECIFIED PERSON. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GRANT PERMISSION TO THE PHYSICIANS SELECTED BY THE MUCHACHOS DRUM & BUGLE CORPS TO SECURE AND ADMINISTER TREAMENT, INCLUDING HOSPITALIZATION, FOR ABOVE SPECIFIED PERSON. I FURTHER UNDERSTAND, THAT IF I DO NOT HAVE MEDICAL INSURANCE, I WILL BE RESPONSIBLE FOR ANY MEDICAL COSTS INCURRED OR NOT COVERED BY INSURANCE. I HEREBY RELEASE THE MUCHACHOS, INC. AND THEIR OFFICERS FROM ANY LEGAL LIABILITY IN THE EVENT OF AN EMERGENCY SITUATION REGARDING HEALTH AND WELL BEING OF THE ABOVE NAMED INDIVIDUAL.

RELEASE OF MEDICAL INFORMATION: MEDICAL PROVIDER/FACILITY IS AUTHORIZED TO RELEASE INFORMATION CONCERNING MEDICAL CONDITION OF ABOVE NAMED INDIVIDUAL.

PARENT/GUARDIAN OR ADULT CORPS MEMBER'S SIGNATURE: _____ DATE:_____