

# John Philip Sousa Jr. Honor Band – MIDWEST Ozark Region

April 26-28, 2012  
Harrison High School  
925 Goblin Dr,  
Harrison, AR. 72601

## MEDICAL FORM

### PLEASE PRINT CLEARLY OR TYPE THE FOLLOWING INFORMATION:

Student Name: \_\_\_\_\_ Gender: \_\_\_\_ Age: \_\_\_\_ School: \_\_\_\_\_

Parent/Guardian 1 Information: Parent/Guardian 2 Information: (if applicable)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of Business: \_\_\_\_\_ Place of Business: \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contacts: (in the event parents/guardians cannot be reached)

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### HEALTH HISTORY: (Use the back of this form for more room, if necessary)

1. Please explain any health problems (heart, lung, kidney, bleeding, fainting, blackouts/convulsions, diabetes, asthma, bronchitis, epilepsy or other).
2. List any allergies (bee, medications, food, etc.), as well as all special dietary needs (vegetarian, kosher, etc.).
3. Is there any illness for which this student is currently receiving treatment and/or medication? YES \_\_\_\_ NO \_\_\_\_  
If yes, please describe treatment and list medication below:

Date – Last Tetanus Shot: \_\_\_\_\_ Date – Last MMR: \_\_\_\_\_  
Family Doctor/Health Center: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Insurance Info:  
Company Name: \_\_\_\_\_ Type: \_\_\_\_\_ Policy #: \_\_\_\_\_

### IN CASE OF MEDICAL EMERGENCY:

I hereby give permission to transport the student named above to an emergency facility or hospital. I also give permission to the physician selected by the Host Chairpersons of the John Philip Sousa National Honor Bands - Midwest Ozark Region or designee, to hospitalize and secure proper treatment for said individual.

All medications will be turned over to the Host Chairpersons of the John Philip Sousa National Honor Bands – Midwest Ozark Region, or designee, and dispensed according to doctor's orders.

**NO STUDENT WILL BE ALLOWED TO PARTICIPATE IN THIS BAND FESTIVAL WITHOUT THIS FORM PROPERLY FILLED OUT.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_