

2015 Carlson Band Camp Staff Health History Record

Name: _____

Address: _____

Telephone number: _____ Cell number: _____

Email address: _____ Date of Birth: _____ Sex: _____

Primary Care Physician: _____

Phone Number: _____

Past Medical History: _____

Current Health Issues: _____

Allergies: _____

Physical Limitations: _____

Emergency Contacts: _____

Medications:

Name	Dose	Frequency

OVER

Medical Insurance Information (Primary): _____

Medical Insurance Information (Secondary): _____

I give my permission to receive medical care in case of illness or injury and/or to have routine care administered while at band camp. (Yes or No) Circle one.

I certify that this information is true to the best of my knowledge.

Signature: _____

Date: _____