QUEEN ANNE'S COUNTY H.S. BAND
EMERGENCY MEDICAL FORM

Name_____ Birth Date _____

Sex _____ Age _____ Social Security # _____

Address _____ Phone # _____

In case of emergency notify:

1. Name _____ Relationship _____ Phone # _____

Address _____
Street and Number City State Zip

2. Name _____ Relationship _____ Phone # _____

Address _____
Street and Number City State Zip

Health History Check:

	Allergies	***Diseases***
Ear Infections _____	Hay Fever _____	Chicken Pox _____
Rheumatic Fever _____	Ivy Poisoning _____	Measles _____
Convulsions _____	Insect Stings _____	German Measles ____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Asthma _____

Operation or Injuries (in the past year) _____
_____
Chronic or Recurring Illness _____
Details of Diseases above _____
Details of Other Diseases _____
Name of Family Physician _____ Phone # _____
Do you carry family medical / hospital insurance? _____
if so indicate:
Carrier _____ Policy # _____
Address of Carrier _____
Phone # of Carrier _____

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In case of emergency, I give permission for my child to be treated by qualified medical personnel.

Signature _____ Date _____