THE BLUE STARS DRUM & BUGLE CORPS
MEDICAL HISTORY FORM

Staff	____	Guard	____
Brass	____	Volunteer	____
Percussion	____	Other	____

GENERAL INFORMATION:

Please print all information. Today's date ___/___/____

Name _____ Age _____ DOB ____/____/____

Address _____ Phone Number _____-_____-_____

City _____ State _____ Zip _____

Health/accident insurance company _____ Policy number _____

ATTACH A PHOTO COPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

Doctor's Name _____ Doctor's Phone No. _____-_____-_____

In case of emergency, notify: Religious preference _____

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Emergency Contact No.: _____-_____-_____ Home Phone _____-_____-_____

Business Phone _____-_____-_____ Cell Phone _____-_____-_____

Alternate contact _____ Alternate's Phone _____-_____-_____

HEALTH HISTORY:

Allergies or Reactions to: (example – aspirin, ibuprofen, sulfa drugs, Penicillin – PCN, latex)

Medications _____ Food, Plants, or insect Bites _____

Are you now, or have you ever been treated for any of the following:

- ☐ **SEIZURES**
- ☐ **DIABETES**
- ☐ **MAJOR ALLERGIES**
- ☐ **Allergies to wasp / bee stings**
- ☐ **ASTHMA**
- ☐ **HEART CONDITION / MURMUR**
- ☐ Positive Tuberculosis Skin Test
- ☐ Autoimmune Disease
- ☐ Chicken Pox / Measles
- ☐ Meningitis (viral or bacterial)
- ☐ Ear Infections / Tonsillitis
- ☐ Sinus Infections, Hearing Loss
- ☐ Bronchitis / Pneumonia
- ☐ **Dental or Gum pain / infections**
- ☐ Tonsillitis
- ☐ Rheumatic Fever / Scarlet Fever
- ☐ Cancer
- ☐ Hepatitis
- ☐ Ulcers – stomach / intestinal
- ☐ Frequent Indigestion
- ☐ Diverticulitis or Colitis
- ☐ Appendicitis
- ☐ Hemorrhoids
- ☐ Hernia / Testicle Lump or Swelling
- ☐ Eczema
- ☐ Hives
- ☐ Acne – requiring long term care
- ☐ Fractures or Broken Bones
- ☐ Shoulder – injury or recurrent pain
- ☐ Elbow – injury or recurrent pain
- ☐ Wrist – injury or recurrent pain
- ☐ Finger – injury or recurrent pain
- ☐ Hip – injury or recurrent pain
- ☐ Knee – injury or recurrent pain
- ☐ Ankle – injury or recurrent pain
- ☐ Foot – injury or recurrent pain
- ☐ Tendonitis or Bursitis
- ☐ Head Aches – more than 3/mo
- ☐ Depression / Anxiety or Panic
- ☐ Back/spinal Injuries or Pain
- ☐ Concussion or Head Injury

List other serious conditions (not checked above) that required surgery or medical treatment.

_____

_____

MEDICATIONS:

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____
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Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Be sure to bring medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Both sides of this form must be completed and turned in upon audition weekend registration. Revised 2/06/11

Name ____ DOB: ___/___/___ Allergies: ____ Emergency Contact No.: ____-____-____

Immunizations:

The following are recommended: Tetanus immunization is required and must have been received within the last ten years. If you had the disease, put "D" and the year. If immunized, check the box and the year received. Attach copy of records.

Yes	No		Date	Yes	No		Date
☐	☐	Tetanus	_____	☐	☐	Hepatitis A	_____
☐	☐	Pertussis	_____	☐	☐	Hepatitis B	_____
☐	☐	Diphtheria	_____	☐	☐	Meningitis MCV4	_____
☐	☐	Measles	_____	☐	☐	Varicella (Chickenpox)	_____
☐	☐	Mumps	_____				
☐	☐	Rubella	_____				

Place an (x) in the box of any conditions you have had frequently during the past four (4) years:

Nose, Ears, Mouth & Throat
- ☐ Nose Bleeds
- ☐ Ear Aches
- ☐ Dental Problems
- ☐ Lumps on Gums or Jaws
- ☐ Sore Throat
- ☐ Enlarged Tonsils

Cardiovascular
- ☐ High Blood Pressure
- ☐ Racing Heart
- ☐ Irregular Heart Beat
- ☐ Chest Pains
- ☐ Light Headed Spells
- ☐ Blackout Spells
- ☐ Heart Murmur
- ☐ Thyroid abnormalities
- ☐ Shortness of Breath
- ☐ Sudden cardiac death in Family
- ☐ Family member with Marfans

Endocrine
- ☐ High or low blood sugars
- ☐ Extreme weight loss or gain
- ☐ Thyroid abnormalities

Head, Neck & Back
- ☐ Frequent Head Aches
- ☐ Fainting Spells
- ☐ Dizzy Spells
- ☐ Motion Sickness
- ☐ Frequent Neck Pain
- ☐ Frequent Back Pain

Gastrointestinal
- ☐ Frequent Indigestion
- ☐ Frequent Nausea
- ☐ Constipation
- ☐ Diarrhea

Genitourinary
- ☐ Painful Urination
- ☐ Kidney Disease or Stones

Respiratory
- ☐ Wheezing
- ☐ Coughing Spells
- ☐ Coughing Up Blood
- ☐ Excessive Sweating at Night
- ☐ Smoke or Chew Tobacco

Skin
- ☐ Acne
- ☐ Itching or Rashes
- ☐ Bleed Easily
- ☐ Bruise Easily
- ☐ Sun Burn Easily
- ☐ Lumps, Cysts, Tumors of Skin
- ☐ Change in appearance of Moles

Musculoskeletal
- ☐ Scoliosis
- ☐ Aching Muscles
- ☐ Swollen Joints / Arthritis
- ☐ Tendonitis
- ☐ Flat Feet
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Foot Pain
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Wrist Pain

CONSENT FOR MEDICAL CARE

Your Name (print):_____as a member / proposed member (circle one) of The Blue Stars Drum and Bugle Corps, shall engage in practices, tours, and performances. The undersigned desires that said member / proposed member (circle one) receive the proper medical treatment in the event of illness or injury while with the Blue Stars. Said signatory consents to the administration of all medical treatments, as may be deemed necessary. The management of The Blue Stars Drum and Bugle Corps in accepting this consent agrees to promptly notify the undersigned parent or guardian, if member is a minor, in the event of any serious accident or illness.

Date: ___/___/___ _____

Signature of parent/guardian (if member is a minor) or Member (if not a minor)

_____

Print name of above signatory

Signatory's Home Phone _____-_____-_____

Signatory's Business Phone _____-_____-_____

Signatory's Cell Phone _____-_____-_____

BE SURE TO ATTACH A PHOTOCOPY OF BOTH SIDES OF YOUR OF YOUR INSURANCE CARD(S).

IF YOU ARE UNDER 18 YEARS OF AGE WHEN YOU ATTEND YOUR FIRST CAMP, MAKE SURE A PARENT/GUARDIAN SIGNS THIS FORM.

Revised 2/06/11