

**University of Arkansas Razorback Marching Band
Health Form**

PLEASE PRINT LEGIBLY

Name _____ SS# _____ Section _____
LOCAL Address _____
LOCAL Phone # _____ Cell # _____
Year in RMB _____ (Including this year)
E-mail Address _____
Permanent Address _____

Who may we contact in case of EMERGENCY? Please list 2 people.

Name _____	Name _____
Phone # _____	Phone # _____
Relationship _____	Relationship _____

Any medical problems or concerns? _____

Do you take any medications on a regular basis? _____ If yes, list the medication and reason taken. _____

Are you allergic to any medications, foods, bee stings, etc.? _____ If yes, list your allergies.

The undersigned student grants authority to any authorized clinic or medical center and assigned staff to perform those procedures and treatments that are deemed necessary for the student named above in the event of a medical emergency. The undersigned also agrees to accept financial responsibility for procedures and treatment administered at said medical establishment.

Student Signature

Date Signed

Parent Signature (required if student is under 18)

Date Signed

Are you covered by medical insurance? _____ If yes, provide the following information:

Insurance Company _____
Insured Name _____ Identification # _____
Group # _____ Phone # _____
Address _____