

TEXAS STATE BAND CAMPS
MEDICAL INFORMATION FORM

Name: _____ Phone: _____

Home Address: _____

City, State, Zip: _____

SSN: _____ DOB: _____ Email: _____

Parent/Guardian Name: _____

Emergency Contact: _____ Phone: _____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD – FRONT AND BACK

Insurance: _____

Policy #: _____ In Whose Name: _____

Primary Physician: _____ Phone: _____

MEDICAL HISTORY

List any health conditions your child has: _____

Allergies (Environmental, food, medication, etc.): _____

MEDICATION

Prescription: _____

Non-Prescription: _____

Dosage: _____

Schedule: _____

Will need assistance with: _____