PURDUE UNIVERSITY BANDS
MEDICAL INFORMATION FORM
2009-2010 SEASON

(PLEASE PRINT!)

LAST NAME _____ FIRST NAME _____ MIDDLE _____

SEX _____ NATIONALITY _____ BIRTH DATE _____ PURDUE ENTRANCE DATE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ TELEPHONE NO. _____

FULL CAMPUS ADDRESS _____ CAMPUS PHONE _____ NAME OF ROOMMATE _____

PARENT OR GUARDIAN _____ ADDRESS AND PHONE (IF DIFFERENT FROM ABOVE) _____

FAMILY PHYSICIAN _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHYSICIAN EMERGENCY PHONE NO. _____ ALTERNATE EMERGENCY PHYSICIAN INFORMATION _____

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COMPLETE FOLLOWING INCLUDING DATES AND SPECIFIC CONCERNS WHERE APPLICABLE:

ALLERGIES, INCLUDING THOSE TO MEDICATIONS:

MEDICATIONS TAKEN ROUTINELY:

CHRONIC DISEASES/EMOTIONAL DISTURBANCES:

PAST SURGERIES (MAJOR AND MINOR):

SERIOUS ILLNESSES/INJURIES:

SIGNIFICANT FAMILY MEDICAL HISTORY:

SPECIFIC EMERGENCY MEDICAL CONCERNS THAT MAY REQUIRE IMMEDIATE ACTION AND DETAILS ON THE ACTIONS TO BE TAKEN IN SUCH CASES. IF YOU CARRY EMERGENCY MEDICATION, PLEASE INDICATE THIS AND WHERE SUCH MEDICATION CAN BE LOCATED:

OTHER IMPORTANT MEDICAL OR PHYSICAL CONDITION INFORMATION THAT MAY BE OF CONCERN DURING MARCHING BAND PARTICIPATION OR OTHER STRENUOUS PHYSICAL ACTIVITY:

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EMERGENCY CONTACT INFORMATION:

_____ _____

PERSON TO CONTACT IN EVENT OF EMERGENCY RELATIONSHIP

_____ _____ _____

DAYTIME PHONE NO. EVENING PHONE NO. OTHER PHONE NO.

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INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

STREET CITY STATE/ZIP

NAME OF POLICY HOLDER (parent, spouse. self) _____

STUDENT'S RELATIONSHIP TO POLICY HOLDER: _____self _____spouse _____child _____other

_____ _____ _____

ID/Subscriber or SS# Account/Group # If Blue Cross, Plan Code

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HEALTH CARE FOR MINORS - REQUEST/AUTHORIZATION:

PLEASE COMPLETE THE FOLLOWING FOR STUDENTS WHO WILL BE UNDER 18 YEARS OF AGE AT THE BEGINNING OF THE SCHOOL SEMESTER:
Pursuant to Indiana Code Paragraph 16-36-1-6 and subject to any limitations listed below, I request and authorize Purdue University Student Health Center, Home Hospital, St. Elizabeth Hospital, or designated emergency medical center medical personnel, agents and employees to provide all reasonably necessary medical care, including but not limited to medical transport, hospital tests, such as pathology, radiology, anesthesia, surgery, and prescription drugs advisable for the health of my child. I acknowledge than no representations, warranties, guarantees as to results or cures will be made.

Student covered by this authorization is _____

_____ _____ _____

Signature of Parent or Legal Guardian Date Adult Witness

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NOTE: A CURRENT MEDICAL INFORMATION FORM MUST BE ON FILE FOR EACH MEMBER OR CANDIDATE FOR MEMBERSHIP IN THE PURDUE "ALL-AMERICAN" MARCHING BAND BEFORE SAID STUDENT WILL BE PERMITTED TO PARTICIPATE IN ANY MARCHING BAND ACTIVITIES. FORM MUST BE FULLY COMPLETED AND RETURN TO **PURDUE UNIVERSITY BANDS, ELLIOTT HALL OF MUSIC, 712 THIRD ST., WEST LAFAYETTE, IN 47907-2005** AS SOON AS POSSIBLE. IT IS THE RESPONSIBILITY OF THE INDIVIDUAL STUDENT TO KEEP THE INFORMATION ON THIS FORM CURRENT AND TO UPDATE ANY CHANGE IN THE INFORMATION IN TIMELY FASHION.

SIGNATURE OF STUDENT _____ DATE _____