Troy Colt Marching Band
Staff & Volunteer
Health History Record

Name (Last, First, M.I.):_____

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Gender: Select below / Male / Female

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Current Health History
List any allergies you have:

List any health problems you have, including current infectious diseases:

List physical limitations, if any:

List any medication you take regularly:
Name: Frequency Dosage

List any dietary restrictions:

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Physician's Name:_____ Phone Number:_____

Address:_____
Street City State Zip

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Emergency Contact
Name:_____Relationship_____

Home Phone:_____ Cell Phone:_____

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I certify that this information is true to the best of my knowledge.

Signature:_____ Date:_____

(Rev. 5-20)