



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: _____

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

Physician's Name: _____ **Phone Number:** _____

Address: _____
Street City State Zip

Emergency Contact

Name: _____ Relationship _____

Home Phone: _____ Cell Phone: _____

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

Signature: _____ **Date:** _____