INSURANCE INFORMATION SHEET FOR "SOUND OF THE SOUTH" MEMBERS
(To be used when filing medical claims)

Student's Name: ____________________________________ Section: _______________

Date of Birth: ____________________ SS#: __________________________

Parent(s)/Guardian(s) Name:
____

Parent(s)/Guardian(s) Address:
____
(Street Address)

City: __________________________________ State: ___________ Zip: ________

Parent(s)/Guardian(s) Phone: (______) ________ - _______________

PLEASE COMPLETE ONE OF THE TWO SECTIONS BELOW
(WHICHEVER IS APPLICABLE TO YOU)
MY HEALTH INSURANCE IS PROVIDED THROUGH…

(A) PARENT(S)/GUARDIAN(S) EMPLOYER
Insured's Name:
____
(Parent/Guardian)
Employer:
____

Address: ____________________________

City: ______________ State/Zip: __________

Group Policy #:________________________

Or ID or Certificate#:___________________

Insurance Co:__________________________

Address:______________________________

City:________________ State/Zip:________

Ins. Co. Phone # (____) _____-____________

B) MY OWN PRIVATE PLAN
Insurance Co.:_______________________

____

Address:
____

City:_______________ State/Zip: _________

Phone: (_____) ______-_________________

*Policy #: ____________________________

Any other ID:
____

*IMPORTANT – Please indicate below if you have a HMO plan with Primary Physician requirements. In other words, before seeing another doctor for treatment and/or surgery, does prior approval have to be obtained from your primary physician? (Circle) YES NO

I certify that, to the best of my knowledge, the information stated above is accurate. I acknowledge that failure to provide accurate health insurance information may result in dismissal

from the “Sound of the South” Marching Band. I certify that the policy listed above is current and that I am covered under said policy. I agree to report changes in my health insurance coverage that may occur during my active participation to the Troy University Band Office.

Signature of Student: ____ Date: _____________

TROY UNIVERSITY “SOUND OF THE SOUTH” MARCHING BAND
MEDICAL HISTORY QUESTIONNAIRE
(THIS FORM TO BE COMPLETED BY INCOMING STUDENT)

FIRST NAME: ______________________LAST NAME: _____________________________

PERMANENT STREET ADDRESS:
____

CITY: ___________________________________ STATE: ___________ ZIP: ____________

PHONE: ____________________DATE OF BIRTH: _____________ GENDER: ___________

I. General Questions Circle One - List or Explain:

1. Do you have any allergies? Yes No _______________________________

2. Do you take medication daily? Yes No _______________________________
(Include birth control pills, prescription and over the counter medications and nutritional supplements, etc.)

3. Do you wear contact lens or glasses? Yes No _______________________________

4. Do you wear dental appliances? Yes No _______________________________

5. Do you wear a hearing aid? Yes No _______________________________

6. Do you have diabetes? Yes No _______________________________

7. Do you have any chronic illnesses or medical problems? Yes No _______________________________

8. Have you ever suffered from exhaustion or heat stroke? Yes No _______________________________

9. Have you ever been instructed by a doctor to reduce or limit physical activity? Yes No _______________________________

10. Has any family member died under the age of 50? Yes No _______________________________

11. Have you ever had any hospitalizations or slept overnight in the hospital? Yes No _______________________________

12. Have you ever had any surgery? Yes No _______________________________

13. Have you ever had an illness that lasted longer than a week? Yes No _______________________________

14. Have you currently or recently (within the last 14 days):

a. Experienced signs and symptoms of COVID19 (to include, but not limited to: fever, fatigue, body aches, sore throat, cough, nasal congestion, shortness of breath, nausea, diarrhea, vomiting) Yes No _______________________________

b. Knowingly had close contact/exposure

to someone with symptoms of COVID-19? Yes No ___________________________________

c. Knowingly had close contact/exposure
to someone diagnosed with COVID-19? Yes No ___________________________________

II. Cardiac

1. Have you ever been told you have high blood pressure? Yes No
2. Have you ever been told you have a murmur? Yes No
3. Have you ever fainted or passed out while exercising? Yes No
4. Has any family member had any heart problems before the age of 50? Yes No
5. Have you or anyone in your family been told they have Marfan's Syndrome? Yes No
6. Have you ever been told you have an irregular heart beat or other heart problems? Yes No
7. Have you ever been evaluated for chest pain? Yes No

If any Yes answers, please explain:

____

____

III. Respiratory

1. Do you have asthma? Yes No
2. Do you have a history of childhood asthma? Yes No
3. Do you have any trouble with your lungs? Yes No
4. Do you have any difficulty with shortness of breath or coughing spells? Yes No
5. Do you have wheezing or coughing after exercise? Yes No
6. Do you have any history of taking asthma medications? (pills or inhalers) Yes No
7. Do you have a history of exposure to tuberculosis or a positive skin test? Yes No

If any Yes answers, please explain:

____

____

IV. Neurologic

1. Do you have a problem with frequent headaches, blurry vision or dizziness? Yes No
2. Have you ever been knocked out? Yes No
3. Have you ever had a concussion? Yes No
4. Have you ever had a seizure? Yes No
5. Do you currently have seizures or epilepsy? Yes No
6. Do you have numbness, tingling or weakness in your arms or legs? Yes No

If any Yes answers, please explain:

____

____

V. Musculoskeletal

1. Do you have any neck problems? Yes No
2. Do you have any back problems? Yes No
3. Have you ever had a back or neck injury? Yes No
4. Do you have any joint problems (shoulders, elbows, hips, knees, hands, fingers, ankles, toes) Yes No
5. Do you have any incompletely healed injuries? Yes No
6. Have you ever had a fracture or a cast? Yes No
7. Do you have arthritis? Yes No

If any Yes answers, please explain:

____

____

____

VI. Food Allergies & Dietary Restrictions

(ex. peanuts, shellfish, vegan, lactose intolerant, etc.)
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____

____

Participation Wellness Disclosure

Are you aware of any reason or condition that might prevent you from participating fully in the "Sound of the South" Marching Band at Troy University?

Yes No If yes, explain:____

Medical Information/Treatment Consent

I, ____________________________, certify that the above information is correct and complete and grant Troy University permission to verify and release any medical information about me in the event of an emergency. If the above information is found to be incorrect, Troy University is not responsible for any injuries related to the falsification of this information.

Student's Signature ______________________________________ Date_____________________

Parental Consent

Required if you are under the age of eighteen (18) years of age

You must provide parental consent to administer the appropriate health care in the case of an emergency. Therefore, by signing this for you, the legal guardian, authorize the Troy University Director of Bands, Assistant Director of Bands, or a staff member of the "Sound of the South" Marching Band, to release any medical information about my son or daughter in the event of an emergency.

Student's Signature _________________________________ Date_____________________

Parent's or Guardian's Signature ____