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)

(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 Phif an requirements. In

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.)

_____

_____

_____

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?