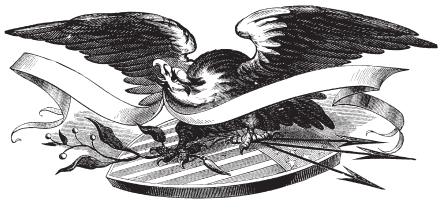

Member #_____

Accepted: _____

Date _____

Name _____

Address _____

Phone _____ Email Address _____

SSN: _____

Employer _____ Occupation _____

Who were you referred by? _____

Do you have any medical conditions? _____

If yes, explain: _____

_____

_____

Person to notify in case of emergency:

Name _____ Phone _____

Relationship _____

Have you ever been convicted of a felony? _____

If yes, please explain: _____

_____

Briefly list your interest in Civil War living history: _____

_____

_____

_____

_____

I hereby discharge and waive any and all claims for bodily injury or accidents occurred while re-enacting and shall not hold officers, or members of the 51st O.V.I. Company B, Inc. responsible for said injury or accident.

Signature of applicant _____ Date _____

Interviewed by _____ Date _____

Sponsored Member _____

Treatment Information Form
Please Print

Name _____ Birthdate _____
Last MI First Month Day Year

Address _____
Street City State Zip

Medical History:

Date of last tetanus shot _____

Allergies _____

Medications _____

Health Conditions _____

Home telephone number _____

Medical Insurance _____
Company Policy No.

Dental Insurance _____
Company Policy No.

Family Doctor _____ Phone (____) _____

Dentist _____ Phone (____) _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

Name _____ Phone (____) _____

Name _____ Phone (____) _____

Name _____ Phone (____) _____

Signature _____ Date _____

Please keep all information up to date. More forms can be obtained through the unit if you need them. this is very important information and will be held in strict confidence. One copy of this form should be placed in your haversack, another copy will be retained by the unit medical officer. Thank You!

Treatment Permission Form
Please Print

Child's Name _____

Birthdate _____

Address _____

Medical History:

Date of last tetanus shot _____

Allergies _____

Medications _____

Health Conditions _____

Parent or Legal Guardian _____

Address _____

Phone: Home _____ Work _____

Medical Insurance _____

Dental Insurance _____

Pediatrician _____ Phone ( ) _____

Family Doctor _____ Phone ( ) _____

Dentist _____ Phone ( ) _____

IN CASE OF AN EMERGENCY, if I cannot be contacted, please notify:

Name _____ Phone ( ) _____

Name _____ Phone ( ) _____

Name _____ Phone ( ) _____

I, the undersigned parent or legal guardian of the above named child, a minor, give permission to a qualified medical treatment facility to render to that child any emergency medical, surgical or dental treatment required. I accept full responsibility for any costs incurred for my child for such emergency treatment. It is understood that every effort will be made to contact me prior to rendering treatment to the child, but that none of the above treatment will be withheld if I cannot be reached.

Signature of
Parent or Guardian _____ Date _____

Witnessed by _____ Date _____