



# MEDICAL RELEASE FORM

PARTICIPANTS UNDER 18 YEARS as of 7/29/17

## SECTION I – BASIC CONTACT INFORMATION

Student Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Gender:  Male  Female

Home Address: \_\_\_\_\_  
STREET  
CITY STATE ZIP COUNTRY

Parent/Guardian #1 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Home/land line  Work  Cell  Home/land line  Work  Cell

Parent/Guardian #2 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Home/land line  Work  Cell  Home/land line  Work  Cell

Family Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Additional Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Home/land line  Work  Cell  Home/land line  Work  Cell

## SECTION II – INSURANCE INFORMATION

Is the student covered by family medical/hospital insurance?  Yes  No

If yes, indicate Insurance Carrier: \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

**Please provide a copy of the insurance card**

## SECTION III– MEDICATIONS

Will student be taking medications during their stay?  Yes  No

(Medications include: prescription, over-the-counter, vitamins, inhalers, etc.)

If student will be taking medications while at the Festival, we need to secure your consent for medication distribution and for the use of medical devices. The medication must be administered by SUMMIT MUSIC FESTIVAL STAFF. However, a limited amount of medication for life threatening conditions should be carried by the student (i.e. bee sting kits, inhalers.)

Please list all (PRESCRIPTION and NON-PRESCRIPTION) medications. Please include the MEDICATION NAME, PRESCRIBING PHYSICIAN, PHYSICIANS' PHONE NUMBER, and the DOSAGE INSTRUCTIONS. Use an additional sheet if needed. When you check in, please provide all medications. In their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

I give consent for the above medication or medical device to be administered by the Summit Music Festival Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

\_\_\_\_\_  
Signature of Parent/Guardian

## SECTION IV – ALLERGIES

Student **does not** have any allergies

Student is **allergic to**:

List allergy. Describe reaction and treatment:  1. Hay Fever  2. Poison Ivy/Oak  3. Insect Stings  4. Food  5. Penicillin  6. Other Drugs  7. Other

## SECTION V – IMMUNIZATIONS *(or attach latest Medical Report)*

Please record the month and year of immunizations. If you do not know the dates or whether the student has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus)	_____	HIB (Haemophilus Influenza B)	_____
Tetanus Booster	_____	Tuberculin Test	_____
Polio	_____	Varicella (Chicken Pox)	_____
MMR (Measles, Mumps, Rubella)	_____	Hepatitis B	_____

## SECTION VI – HEALTH HISTORY *(OR ATTACH LATEST MEDICAL REPORT)*

Please know that we value your privacy. Health History information is available only to the designated Summit Music Festival staff.

- |  |   |
|--|---|
| <input type="checkbox"/> 1. Recent injury, illness or infectious disease | <input type="checkbox"/> 16. German Measles                 |
| <input type="checkbox"/> 2. Chronic or recurring illness                 | <input type="checkbox"/> 17. Mumps                          |
| <input type="checkbox"/> 3. Asthma                                       | <input type="checkbox"/> 18. Tuberculosis                   |
| <input type="checkbox"/> 4. Homesickness                                 | <input type="checkbox"/> 19. Hepatitis                      |
| <input type="checkbox"/> 5. Frequent Ear Infections                      | <input type="checkbox"/> 20. Joint problems (knees, ankles) |
| <input type="checkbox"/> 6. Seizure Disorder or Convulsions              | <input type="checkbox"/> 21. Fractures                      |
| <input type="checkbox"/> 7. Dizziness during or after exercise           | <input type="checkbox"/> 22. Frequent Headaches             |
| <input type="checkbox"/> 8. Chest pain during or after exercise          | <input type="checkbox"/> 23. Head Injury                    |
| <input type="checkbox"/> 9. Heart Defect/Disease                         | <input type="checkbox"/> 24. Eating Disorder                |
| <input type="checkbox"/> 10. Hypertension                                | <input type="checkbox"/> 25. Diarrhea or constipation       |
| <input type="checkbox"/> 11. Bleeding/Clotting Disorders                 | <input type="checkbox"/> 26. Frequent Stomachaches          |
| <input type="checkbox"/> 12. Diabetes                                    | <input type="checkbox"/> 27. Wears glasses or contacts      |
| <input type="checkbox"/> 13. Mononucleosis (in last 12 months)           | <input type="checkbox"/> 28. Been Hospitalized              |
| <input type="checkbox"/> 14. Chicken Pox                                 | <input type="checkbox"/> 29. Wears a Medic Alert ID         |
| <input type="checkbox"/> 15. Measles                                     |   |

Does the student have a history or prone to any of the following (Please check all that apply).

Please list the number and provide explanation for any checked items if needed:

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**Date of Last Physical Exam** (Recommended within 12 months of 7/24/2016) \_\_\_\_\_

**Any other concerns or restrictions the staff needs to know:**

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