Summit Music Festival 2018

MINOR MEDICAL RELEASE FORM

Minor if not 18 by 7/21/18

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.

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

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

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

_____

_____

Date of Last Physical Exam (Recommended within 12 months of 7/21/2018) _____

Any other concerns or restrictions the staff needs to know:

_____

_____

SECTION VII – AUTHORIZATION

My child **has permission** to engage in all festival activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the SMF staff. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury. The effective dates for this authorization are July 22 through August 12, 2018.

Signature of Parent or Guardian: _____ **Date:**_____