

Arts Mission Health Form

Sing Out Next Stage

This form must be completed and signed by the participant's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while the workshop is in session. **This form will be returned to you if it is incomplete.** Please type or print in **black or blue ink.** (This form will be shredded at the conclusion of the workshop.)

PARTICIPANT INFORMATION:

Participant's Name _____
Permanent Address _____ Date of Birth _____ Sex _____
City/State/Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION:

Person to contact first:	Backup contact (relative or friend):
Name _____	Name _____
Relation to participant _____	Relation to participant _____
Daytime Phone _____	Daytime Phone _____
Evening Phone _____	Evening Phone _____

INSURANCE POLICY INFORMATION:

Is the above named participant is covered by health insurance: Yes No

If yes, please provide the following information to expedite treatment:

Policy Holder's (P.H.) Name: _____ P.H.'s Date of Birth _____
Address _____ Relation to Participant _____
City/State/Zip _____
Insurance Company _____
Insurance Company's Address _____
Policy # _____ Plan # _____

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named participant, authorize the Arts Mission staff to seek medical treatment for the participant as they see necessary at Duke University Medical Center (for NC camps), Princeton Community Hospital (for WV camp) or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the Arts Mission staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named participant. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Arts Mission staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Arts Mission staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

Legal Guardian's Signature

Print Name

Date

(Please complete next side)

DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING? (If yes, please describe)

Drug Allergies: _____

Food Allergies: _____

Allergies to insect bites: _____

Special Dietary Needs: _____

Asthma: _____

Frequent Headaches: _____

Dizziness or seizures: _____

LIST:

Other health problems: _____

Limitations of Activities: _____

Medications the participant is currently taking: _____

(Please note: Our staff cannot administer any medications, prescription or non-prescription to participants. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the participant will need to take medications while attending our workshop, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will participant require any specific treatment for a medical/emotional condition while attending our workshop?

If yes, please explain. _____

Are immunizations up to date? Yes No

If no, please explain: _____

Reason for any hospitalization in the past 5 years:

PHYSICIAN'S INFORMATION:

Physician's Name: _____

City/State: _____

Telephone: _____