Orchestra Retreat
Medical Information Form & Release Form

If Parent is attending, fill out first 4 lines of this section and the Allergies section; otherwise you must complete both pages of this form and attach a copy of your medical insurance form. Please be sure to fill out one form for each student that will be attending.

Student's Name: _____

Gender (circle): Male / Female **Birth Date:** _____ **Weight:** _____

Home Address: _____

Parent/Guardian: _____ **Day Phone:** _____ **Evening Phone:** _____

Will a Parent be available in an emergency? ___ Or to bring Child home if necessary? ___ If not, identify the responsible person(s):

(1) _____ **Relationship to Student:** _____ **Day Phone:** _____ **Evening Phone:** _____

(2) _____ **Relationship to Student:** _____ **Day Phone:** _____ **Evening Phone:** _____

Student's Physician: _____ **Address:** _____ **Phone:** _____

Do you carry family medical/hospital insurance? _____ **If so, what carrier?** _____

Policy/Group No: _____ ***(Please attach a photocopy of your medical Insurance Card.)***

MEDICAL NEEDS *(Explain in detail on Page 2 if necessary.)*
Is the student currently receiving any medication or treatment? If so, please Indicate:

Medication: _____ **For what?** _____ **How often?** _____
Medication: _____ **For what?** _____ **How often?** _____
Other: _____ **For what?** _____ **How often?** _____

(Medications must be delivered in their original containers to the Staff before departure with very complete written instructions for administering the medications.)

ALLERGIES *(Explain in detail on Page 2 if necessary.)*
Any allergies to MEDICATIONS? If so, list: _____
Any allergies to FOODS? If so, list: _____
Is this student allergic to BEE STINGS? _____ **OTHER allergies?** _____

MEDICAL HISTORY (*Check ALL that apply and explain in detail on Page 2 if necessary.)*

- ❑ **Asthma**
- ❑ **Diabetes**
- ❑ **Hernia**
- ❑ **Convulsions**
- ❑ **Fainting Spells**
- ❑ **Epilepsy**
- ❑ **Rheumatic Fever**
- ❑ **Sleeping Problems**
- ❑ **Sleep Walking**
- ❑ **Frequent ear infections**
- ❑ **Stomach Aches**
- ❑ **Emotional Problems** (explain)
- ❑ **Bleeding Disorder**
- ❑ *List others on Page 2 and staple.*

Golden Gate Philharmonic

IMMUNIZATION
(Please check all that the camper has had or been immunized against.)

- ❑ **Chicken Pox Date:**_____
- ❑ **Measles Date:**_____
- ❑ **Polio Vaccine Date:**_____
- ❑ **German Measles Date:**_____
- ❑ **Mumps Date:**_____
- ❑ **Tuberculin Test Date:**_____
- ❑ **Date of last DPT or Tetanus Vaccine:**_____

EXPLANATION(S):

PERMISSION FOR NON-PRESCRIPTION MEDICATIONS
Non-aspirin pain relievers and other nonprescription, ingestible medications are available at the Camp on a limited basis. Therefore, if you anticipate that your child will need them, you must deliver them to the Staff on the morning of departure.

If necessary, may the Orchestra staff administer the following medications? *(Please initial.)*

(1) Aspirin	**Yes**_____	**No**_____
(2) Non-Aspirin substitute	**Yes**_____	**No**_____
(3) Cold Remedies (non-prescription)	**Yes**_____	**No**_____

EMERGENCY MEDICAL TREATMENT
AUTHORIZATION AND RELEASE

My Child is in good health, and I accept all financial responsibility for my Child's attendance at Camp.

IN CASE OF A MEDICAL OR SURGICAL EMERGENCY, I hereby authorize the physician selected by the Orchestra Director to secure all proper and required treatment for my child. All expenses for treating the child shall be paid for by the parent or guardian. Additionally, it is my understanding that if my child must be removed from the Camp for any reason, it will be my responsibility to arrange transportation home for him/her.

SIGNATURE
Parent/Legal Guardian: ..... **Date:** .....

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Parent/Legal Guardian: ..... **Date:** .....