



## 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.)

- |                                   |  |  |   |  |
|-----------------------------------|--|--|---|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Convulsions     | <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Frequent ear infections      | <input type="checkbox"/> Bleeding Disorder                 |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Stomach Aches                | <input type="checkbox"/> List others on Page 2 and staple. |
| <input type="checkbox"/> Hernia   | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Sleep Walking     | <input type="checkbox"/> Emotional Problems (explain) |  |

