

**Pacific Crest Youth Arts Organization
Medical Information Form**

Performer	Last Name, First Name: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Street Address: _____ City, ST, Zip _____ Birth Date: _____ Soc Sec # _____ - _____ - _____ <i>(Required by medical personnel for treatment)</i>
Parent or Guardian	Last Name, First Name: _____ Street Address: _____ City, ST, Zip _____ Home Phone: _____ Mobile or Work: _____
Emergency Contact 1	Last Name, First Name: _____ Relationship to member: _____ Home Phone: _____ Mobile or Work: _____
Emergency Contact 2	Last Name, First Name: _____ Relationship to member: _____ Home Phone: _____ Mobile or Work: _____
Family Physician	Last Name, First Name: _____ Street Address: _____ City, ST, Zip _____ Phone: _____
Medical Insurance	Do you have health or accident insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Company Name: _____ Street Address: _____ City, ST, Zip _____ Agent's or Group Name: _____ Member insured under: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Own Policy <input type="checkbox"/> Other _____

Medical Information

Medicine Allergies and Use Check the medications you use or are allergic to:	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"></td> <td style="width:10%; text-align:center">Taking</td> <td style="width:10%; text-align:center">Allergic</td> <td style="width:10%;"></td> <td style="width:10%; text-align:center">Taking</td> <td style="width:10%; text-align:center">Allergic</td> <td style="width:10%;"></td> </tr> <tr> <td></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>aspirin</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>demerol</td> </tr> <tr> <td></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>penicillin</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>antibiotics</td> </tr> <tr> <td></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>sulfa</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>sedatives</td> </tr> <tr> <td></td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>codeine</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>(other)</td> </tr> </table>		Taking	Allergic		Taking	Allergic			<input type="checkbox"/>	<input type="checkbox"/>	aspirin	<input type="checkbox"/>	<input type="checkbox"/>	demerol		<input type="checkbox"/>	<input type="checkbox"/>	penicillin	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics		<input type="checkbox"/>	<input type="checkbox"/>	sulfa	<input type="checkbox"/>	<input type="checkbox"/>	sedatives		<input type="checkbox"/>	<input type="checkbox"/>	codeine	<input type="checkbox"/>	<input type="checkbox"/>	_____							(other)
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						(other)																																					
	List any food allergies you have, e.g. peanuts _____ _____																																										
History of Treatments Describe medical attention received during the past two years.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; text-align:center">Date</td> <td style="width:45%; text-align:center">Illness, Symptom, Injury</td> <td style="width:40%; text-align:center">Treatment</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Date	Illness, Symptom, Injury	Treatment	_____	_____	_____	_____	_____	_____	_____	_____	_____																														
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Pacific Crest Medical Information Form (Continued)

Current Medication

Are you taking prescription medications regularly? Yes No

Medication	Dosage	When Taken	For What?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you taking over-the-counter drugs regularly? Yes No
If yes, please list:

Medical History

Date of last Tetanus shot ___/___/___

Do you wear glasses? Yes No Contacts? Yes No

Do you smoke cigarettes? Yes No

Illnesses you have had or are prone to have.

- | | | |
|---|--|---|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Nervous Exhaustion |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Polio | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma |

List any other serious illnesses or operations you've had:

Illnesses or conditions you have had, or prone to have, either *sometimes or frequently*.

Nose and Throat:

- congested nose
- runny nose
- sneezing spells
- head colds
- nose bleeds
- sore throat
- enlarged tonsils
- hoarse throat
- bee sting allergy

Mouth:

- dental problems
- itching or burning
- sore tongue
- taste changes

Skin:

- acne
- itching and bleeding
- bleeds easily
- bruises easily
- sunburns easily

Head and Neck:

- frequent headaches
- neck pains and swelling

Respiratory:

- wheezes
- coughing spells
- coughs up blood
- excessive swelling
- inadequate sweating
- sun "poisoning"

Cardiovascular:

- high blood pressure
- racing heart
- chest pains
- dizzy spells
- shortness of breath
- swollen feet or ankles

Musculoskeletal:

- aching muscles
- swollen joints

**Pacific Crest Youth Arts Organization
Release and Assumption of Risk
and Consent to Medical Treatment Release Form**

I have signed and delivered this document to you on behalf of the participant named below.

_____ (“Performer”) has my permission to participate in all activities arranged by Pacific Crest Youth Arts Organization (“Pacific Crest”) from December 2009 through August 2010.

I am aware that during any of the Pacific Crest activities – including, without limitation, auditions, rehearsals, trips, and competitions – certain hazards may occur, including but not limited to, the hazards of accidents or illness, which may occur at places without medical facilities; hazards created by the forces of nature; and hazards of travel by air, train, bus, automobile, and other means, including physical exercise, marching, running, and walking.

I understand and do hereby assume all of the above-mentioned risks and will hold Pacific Crest harmless from any and all liability whatsoever which may arise out of participation in any activities arranged for the Performer by Pacific Crest, or during any travel in private vehicles to and from any Pacific Crest rehearsals or functions. This document shall serve as a release of all claims for personal injury to the Performer and an assumption of risk binding upon my heirs, executor and administrators, and all members of my family.

In an event of Performer’s illness, I do hereby authorize any of the directors, officers, managers, or chaperones of Pacific Crest who are present at the place of occurrence to consent to whatever x-ray examination, anesthetic, medical, surgical, or dental diagnosis, treatment, and/or hospital care that may be considered necessary for the Performer in the best judgment of the attending physician, surgeon, or dentist and to be performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. I recognize that the directors, officers, managers or chaperones consenting to such health care may reasonably and in good faith rely upon the advice furnished to him or her by the attending licensed healthcare provider(s).

Signed:

_____ Date

_____ Performer

_____ Date

_____ Parent/Guardian (if performer is under 18)