Pacific Crest Youth Arts Organization
Medical Information Form and Authorization to Treat

Performer	Last Name, First Name ____________ ☐ Male ☐ Female
	Birthdate: ____________ ☐ Brass ☐ Battery ☐ Front Ens ☐ Guard ☐ Drum Major
	Address: ____________
	City: ____________ State ____ Zip ____
Parent or Guardian No. 1	Last Name, First Name ____________
	Home Phone: ____________ Mobile or Work: ____________
Parent or Guardian No. 2	Last Name, First Name ____________
	Home Phone: ____________ Mobile or Work: ____________
Emergency Contact	Last Name, First Name ____________
	Relationship to Performer: ____________
	Home Phone: ____________ Mobile or Work: ____________
Physician and Medical Insurance	Dr. Name ____________ Phone: ____________
	Do you have health or accident insurance? ☐ Yes ☐ No
	Policy Holder: ____________ Company: ____________
	Policy #/Medical # ____________

GENERAL QUESTIONS	Yes	No
Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
Do you have any of the following ongoing medical conditions? *(Check all that apply)* ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Anemia ☐ Allergies ☐ Infections	☐	☐
Have you ever spent the night in a hospital?	☐	☐
Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS	**Yes**	**No**
Does your heart ever race or skip beats (irregular beats) during exercise?	☐	☐
Has a doctor ever told you that you have any of these heart problems? *(Check all that apply)* ☐ High Cholesterol ☐ Heart Infection ☐ Heart Murmur ☐ Irregular Heart Beat ☐ High Blood Pressure ☐ Other [ ]	☐	☐
Has a doctor ever ordered a test for your heart, e.g. EKG?	☐	☐
Do you feel lightheaded or more short of breath than expected during exercise?	☐	☐
Have you ever had an unexplained seizure?	☐	☐
MEDICAL QUESTIONS	**Yes**	**No**
Have you required x-rays or treatment for a neck or spinal problem?	☐	☐
Do you have a bone, muscle, or joint injury that bothers you frequently?	☐	☐
Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐
Do you have rashes or other skin problems?	☐	☐

MEDICAL QUESTIONS (CONTINUED)	Yes	No
Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
Have you ever used an inhaler or taken asthma medicine?	☐	☐
Have you had infectious mononucleosis (mono) within the last six (6) months?	☐	☐
Do you have frequent muscle cramps during or after exercise?	☐	☐
Have you had a hit or blow to the head that caused confusion, prolonged headache, or memory problem?	☐	☐
Do you have headaches with exercise or a history of migraines?	☐	☐
Have you ever become ill while exercising in the heat?	☐	☐
Are you on any special diet or do you avoid certain foods?	☐	☐
Do you have a history of a seizure disorder *If so, list medications on next page.*	☐	☐
Do you have severe allergies to any drugs, foods, or pollens? *Please list on next page.*	☐	☐
Have you ever had any broken or fractured bones or dislocated joints?	☐	☐
Do you or have you used alcohol or other recreational drugs?	☐	☐
Have you ever had a stress fracture?	☐	☐
Have you ever had hepatitis, liver problems, or yellow jaundice?	☐	☐
Do you have any hearing or other ear problems?	☐	☐

Please return this form with a copy of the front and back of your medical insurance card

Performer Last Name, First Name ____

Please explain any YES answers (from first page of form) or list any serious medical conditions not mentioned on the first page of this form:

____
____
____

Check any of the following that you CANNOT use due to allergy or adverse reaction:

☐ Aspirin ☐Ibuprofen ☐ Penicillin ☐ Sulfa Drugs ☐ Latex
☐ Other ____

Other Allergies (i.e. food, pollen, etc):

____
____

Do you eat a strict vegetarian diet? ☐Yes ☐ No

List any **over-the-counter** or **prescription drugs** and **herbal supplements** you take. (If you carry an EpiPen for severe allergies, list it as well):

Medication	Dose

Write the dates when the following **immunizations** or **booster dose** of the immunizations was given:

Tetanus, Diphtheria, Pertussis (Tdap)	_________	Hepatitis A	_________
Varicella (Chickenpox)	_________	Measles, Mumps, Rubella (MMR)	_________
Hepatitis B	_________	HPV (Gardasil)	_________
Combined Seasonal and Swine Flu	_________	Meningitis (Menactra)	_________

CONSENT FOR MEDICAL CARE

By my/our signatures below, to the best of my/our knowledge, the answers to the questions on this two-page form are complete and correct. If selected as a member of Pacific Crest Drum and Bugle Corps, the performer shall engage in rehearsals, physical conditioning, tour and performances with the corps. I/WE desire that the student receive proper medical treatment in the event of illness or injury while with Pacific Crest. Said signatory consents to the administration of medical treatments as may be deemed necessary. The management of Pacific Crest in accepting this consent agrees to promptly notify the undersigned parent/guardian, if the student is a minor, in the event of any serious accident or illness.

Signed and Dated:

_______________________________ _______________________________
Date Performer Signature

_______________________________ _______________________________
Date Parent/Guardian Signature *(if performer is under 18)*

____
Print Full Name of
Parent/Guardian