

Summer Arts Institute Medical Form

This form MUST be signed by a physician for admittance to the camp.

Please print all information.

Participant's Name: _____

(Last) (First) (Middle)

Parent's Names: _____ EMERGENCY PHONE NUMBERS

Address: _____ (____) _____

_____ (____) _____

Medical Insurance Information (a copy of the front and back of the insurance card under which you are currently covered must be submitted with this form):

Insurance company (Name & Address): _____

Group Name: _____ Relationship to Participant: _____

Member's Name: _____ Group Number: _____

Member Number: _____

Plan Code: _____

The following MUST be filled out by your family physician.

Has the participant named above had any of the following? (Check those that apply)

____ Diabetes ____ Allergies ____ Recurring headaches

____ Heart trouble ____ Mumps ____ Head injury/unconsciousness

____ Asthma, hay fever ____ Measles ____ Shortness of breath

____ Epilepsy ____ Drug allergies ____ Disease or injury of bones

____ Convulsions ____ Chicken pox ____ Dizziness or fainting

____ Other: _____

If any of the above has been checked, please explain. _____

IMMUNIZATION RECORD (please give dates):

Tetanus: _____ Polio: _____ Measles, mumps, rubella: _____

Please answer the following:

In the past two years, has physical activity been restricted? Yes ____ No ____

In the past two years, has the participant been hospitalized? Yes ____ No ____

Is the participant currently on medication? Yes ____ No ____

Does the participant have a communicable disease or any medical problem

that might affect participation in the Summer Arts Institute? Yes ____ No ____

If any of the above were answered "Yes", please explain: _____

Please explain any other restrictions or medical concerns: _____

Physician's Name (please print): _____ Telephone: (____) _____

Address: _____

Physician's signature: _____ Date: _____