



Glory Independent Winterguard
Medical Release Form

PERFORMER INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip _____

Cell Phone (____) _____ Email Address _____

EMERGENCY CONTACT INFORMATION- include Parents/Guardians

Name _____ Relationship to Member _____ Contact Information _____

MEDICAL INSURANCE INFORMATION*

Medical Insurance Company _____ ID Number _____

Group Number _____

Name of Primary Insured _____ Relationship to Participant _____

Primary Insured's Employer (if insured through employer) _____

Other Important Policy Information _____

*____ Initial here if you have no medical insurance. Understand your liability for 100% of the cost of medical treatment.

-Attach a photocopy of the front and back of the participant's insurance card to this document-

PRIMARY CARE PHYSICIAN INFORMATION

Name _____ Practice/Business Name _____

Address _____

City _____ State _____ Zip _____ Phone (____) _____

***____ Initial here if you have no primary care physician. Members should undergo a physical exam before auditioning



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MEDICAL HISTORY INFORMATION

Do you have any food allergies? Yes No If Yes, please describe _____

Do you have any drug allergies? Yes No If Yes, please describe _____

Do you currently take any medications? Yes No If Yes, please list _____

Do you have currently or have you ever had?

- | | | | |
|----------------------------|--|---------------------------|--|
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ankle Problems or Injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heat Exhaustion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety/Panic | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Pain or Injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Concussion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knee Problems or Injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you checked "yes" for any of the conditions above, please explain: _____

Have you ever had any fractures? Yes No If Yes, location _____ Date _____

Have you ever had any surgeries? Yes No If Yes, location _____ Date _____

Do you have ANY other medical conditions? Yes No If Yes, please describe: _____

When was your last Tetanus booster (date) _____

A tetanus booster is current for 10 years. All 2022 members are required to have a tetanus booster received during or after April 9, 2012.

When was your last physical examination? (date) _____



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MEDICAL RELEASE

In the event of participant’s illness or injury which is minor in nature, I do hereby authorize any of the directors, officers, managers, other volunteers or staff of Arsenal Performing Arts Inc. who are present at the place of occurrence to provide basic first aid and/or administer the following as indicated:

- | | | |
|---|--|---|
| <input type="checkbox"/> Tylenol or other non-aspirin pain reliever | <input type="checkbox"/> Ibuprofen (or equivalent) | <input type="checkbox"/> Benadryl (or equivalent) |
| <input type="checkbox"/> Antibiotic ointment applied to cuts etc. | <input type="checkbox"/> Imodium (or equivalent) | <input type="checkbox"/> Naprosyn (or equivalent) |

I understand that participants are encouraged to be prepared by carrying their own small personal supply of each of these common over the counter medications.

In an event of participant’s illness or injury which requires professional medical attention, I do hereby authorize any of the directors, officers, managers, other volunteers or staff of Arsenal Performing Arts Inc. 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 participant 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 other volunteers or staff consenting to such health care may reasonably and in good faith rely upon the advice furnished by the attending licensed health care provider(s).

I understand that I will be responsible for 100% of the cost of professional medical intervention. As applicable, the parent or guardian will be contacted by the medical provider by phone to provide a method of payment for all applicable fees and co-pays if payment is required at the time service is rendered.

By signing I acknowledge awareness of the foregoing disclosures, and attest that to the best of my knowledge the information provided by me is complete, accurate and current. I further agree to provide updated information as needed so that the information remains current.

Parent/Guardian signature required if participant is under 18 years of age at time of signing.

Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____