ARSENAL PERFORMING ARTS

Arsenal Drum and Bugle Corps
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 Home Phone Cell Phone Work Phone

_____

_____

_____

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	□ Yes □ No	Fainting Spells	□ Yes □ No
Ankle Problems or Injuries	□ Yes □ No	Heart Disease	□ Yes □ No
Anemia	□ Yes □ No	Heat Exhaustion	□ Yes □ No
Anxiety/Panic	□ Yes □ No	Hernia	□ Yes □ No
Back Pain or Injuries	□ Yes □ No	High Blood Pressure	□ Yes □ No
Concussion	□ Yes □ No	Hypoglycemia	□ Yes □ No
Depression	□ Yes □ No	Knee Problems or Injuries	□ Yes □ No
Dizziness	□ Yes □ No	Low Blood Pressure	□ Yes □ No
Diabetes	□ Yes □ No	Migraine Headaches	□ Yes □ No
Epilepsy	□ Yes □ No	Mononucleosis	□ Yes □ 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 July 20, 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:

☐ Tylenol or other non-aspirin pain reliever	☐ Ibuprofen (or equivalent)	☐ Benadryl (or equivalent)
☐ Antibiotic ointment applied to cuts etc.	☐ Imodium (or equivalent)	☐ 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** _____