

BLUE WATER THEATRE COMPANY
CONFIDENTIAL 2019-2020 HEALTH & MEDICAL RECORD

General Information:

Name _____

Date of Birth _____ Male Female Grade (2019-2020) _____

Street Address _____

City/State/Zip _____

Home Phone Number _____

Health Insurance Company _____

Health Insurance Policy Number _____

In case of emergency, notify:

Name _____ Relationship _____

Address _____

Home Phone Number _____

Business Phone Number _____

Cell Phone Number _____

Alternate Emergency Contact Name _____

Alternate Contact's Phone Number _____

Medical History:

Are you now, or have you ever been treated for any of the following? If yes on any option, please explain:

Condition

Yes No Asthma _____

Yes No Diabetes _____

Yes No Hypertension _____

Yes No Heart Disease _____

Yes No Stroke/TIA _____

Yes No COPD _____

Yes No Ear/sinus problems _____

Yes No Muscular/skeletal condition _____

Yes No Menstrual problems _____

Yes No Bleeding disorders _____

Yes No Fainting spells _____

Yes No Thyroid disease _____
 Yes No Kidney disease _____
 Yes No Sickle cell disease _____
 Yes No Seizures _____
 Yes No Sleep disorders _____
 Yes No GI problems _____
 Yes No Surgery _____
 Yes No Serious Injury _____
 Yes No Other _____

Allergies: (include reaction)

Medication _____
 Food _____
 Plants/Insect Bites _____

Immunizations: (please mark below or attach copy of immunization record)

	Date Received
Yes <input type="checkbox"/> No <input type="checkbox"/> Tetanus	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Pertussis	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Diphtheria	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Measles	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Mumps	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Rubella	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Polio	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Chicken pox	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis A	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Hepatitis B	_____
Yes <input type="checkbox"/> No <input type="checkbox"/> Influenza	_____

Medications: *List all medications currently used. Please include Inhalers and EpiPen information, even if they are for occasional or emergency use.*

Medication _____
 Strength _____ Frequency _____
 Reason _____
 Approximate Date Started _____ Temporary Permanent

Medication _____
Strength _____ Frequency _____
Reason _____
Approximate Date Started _____ Temporary Permanent

Medication _____
Strength _____ Frequency _____
Reason _____
Approximate Date Started _____ Temporary Permanent

Medication _____
Strength _____ Frequency _____
Reason _____
Approximate Date Started _____ Temporary Permanent

Medication _____
Strength _____ Frequency _____
Reason _____
Approximate Date Started _____ Temporary Permanent

Please attach additional sheets if necessary

Parental Informed Consent and Hold Harmless/Release Agreement

I understand that participation in Blue Water activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Blue Water Theatre Company, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this

participation. I approve the sharing of the information on this form with Blue Water volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Blue Water activities. In case of an emergency involving my child, I understand that every reasonable effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

- Without restrictions
- With special considerations or restrictions (explain)

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any Blue Water activity.

Student's Name _____

Student's Signature _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

PLEASE ATTACH A PHOTOCOPY OF THE STUDENT'S HEALTH INSURANCE CARD.

The information contained in this form will be considered valid and up-to-date through August 31, 2019. Students participating in multiple productions between now and then will not be asked to fill out the form multiple times. Parents are expected to notify Blue Water Theatre Company of any changes in a student's health history or information.