



WORKSHOP MEDICAL FORM

All information on this form is considered to be confidential, and will be treated accordingly. The form must be completed by the parent or guardian, or by the participant if they are eighteen years of age or older.

~ Please *print* all information.

Name _____ Sex: M ___ F ___ Age: _____

Address: _____

Birth Date: _____

Parent or Guardian Information:

	Mother	Father
Name		
Address		
Phone (home)		
Phone (work)		

Alternate contact in event of emergency:

Name _____ Relationship: _____

Phone: Home: _____ Work: _____

Health Insurance Information: Please attach a *photocopy* of **Alberta Health Care Card**

Alberta Health Care Number: _____

Family Physician: Name: _____ Phone: _____

Allergies

List ALL known allergies (including medication, food, inhalants, etc.)

ALLERGY	REACTION	TREATMENT

Medication

Please list all current medications (prescription and over the counter)

MEDICATION	DOSAGE & TIMES TAKEN	REASON

All prescription medication must be in the *original, labeled* container. Please ensure you have enough medication for the entire time away with the orchestra.

Medical history

Does the participant have any of the following:

- Diabetes Yes ___ No ___ Chronic Bronchitis Yes ___ No ___
- Epilepsy Yes ___ No ___ Rheumatic Fever Yes ___ No ___
- Asthma Yes ___ No ___ Stomach or Bowl Disease Yes ___ No ___
- Arthritis Yes ___ No ___ Glandular Problems Yes ___ No ___
- Convulsions Yes ___ No ___ Emotional Illness Yes ___ No ___
- Heart Disease Yes ___ No ___ Fainting Spells Yes ___ No ___
- Kidney Disease Yes ___ No ___

If yes, remarks _____

Does, or has the participant had, any difficulties with any of the following:

- Eyes Yes ___ No ___ Remarks _____
- Wearer of Contact Lenses Yes ___ No ___ Remarks _____
- Ears Yes ___ No ___ Remarks _____
- Nose Yes ___ No ___ Remarks _____
- Throat Yes ___ No ___ Remarks _____
- Digestion Yes ___ No ___ Remarks _____

Is the participant presently undergoing any treatment for an illness or injury incurred within the past year? Yes ___ No ___

If yes, please describe _____

Does the participant have any medical concerns that would influence his/her participation in any activities? Yes ___ No ___

If yes, please explain _____

Will you permit chaperones to administer light remedies, specifically for headaches, colds or upset stomach (such as Tylenol, Gravol, cold medication, etc.)?

Yes ___ No ___

If any exceptions, please specify _____

Does the participant have any personal problems of which the chaperones should be aware? Yes ___ No ___

Are there any foods the student cannot eat because of health reasons or because of religious or other beliefs? Yes ___ No ___

If yes, please specify _____

Other Information or Comments about the general health of the participant

Full Name of Person completing the form: _____

(Parent/Guardian signature or participant if over 18)

(Date)

Please note: This form must be completed and will be kept on file and used for the Banff workshop. It is your responsibility to notify the Orchestra Manager and update this form. The care of your child while away depends on accurate, up-to-date information.