METROPOLITIAN DETROIT YOUTH CHORUS
Medical Treatment Authorization
Effective September 1, 2017 to August 31, 2018

____ ___________ ___________________
Chorus Member Legal Name Age Date of Birth

________________________________ ______________________________ ______ _____________
Address City State Zip Code

__________________________ _________________________ _____________________________
Parent Cell # Member Cell # Home Phone

CONTACT/INSURANCE INFORMATION:

______________________________ ____________________________
Parent /Guardian Contact #

______________________________ ____________________________
Parent/Guardian Contact #

______________________________ ___________________________ __________________
Other Emergency Contact Phone # Relationship to Member

______________________________ ___________________________
Name of Physician Phone # of Physician

_______________________________ _______________________________
Insurance Carrier Policy #

_______________________________ _______________________________
Subscriber's Name Member #

In the event of a medical emergency, I/we authorize any representative of the Metropolitan Detroit Youth Chorus Board of Trustees to seek and consent to urgent/emergency care, x-ray, hospitalization, or other immediate medical treatment, on the advice of a licensed physician, for the above named chorus member. This authorization is effective while this chorus member is under the general or direct supervision of the Board of Trustees.

(Please Initial here) __________ Should the need arise, I/we also give consent for this chorus member to be administered over-the-counter medication (i.e. acetaminophen, ibuprofen, cough medicine, etc.) dispensed by an adult with the following **EXCEPTION(S):**

Please list any allergies to medication OR food, or food sensitivities. (Ex: Gluten allergy or Gluten sensitivity)

____

Please list any medications (Prescribed or OTC/Vitamins/Supplements) currently being taken along with strength and dosage (how often it is being taken):
____

Please list any medical or psychological conditions not addressed on next page (ADHD, Asperger's Syndrome, anxiety, etc.):

____

____

VACCINATIONS:

All vaccinations up to date: Yes _____ No _____ *** Tetanus Vaccine *** ___________ (please provide date)

If no, please explain ____

(Continued on back)

Chorus Member's Name: ______________________________

History: **Does the member have any of the following?**

	Yes	No	If yes, please explain:
***Head, ears, nose, throat:**			
Hearing/speech deficits	_____	_____	______________________________
Headaches	_____	_____	______________________________
Seizure	_____	_____	______________________________
Chronic Sore throats	_____	_____	______________________________
Chronic Ear infections	_____	_____	______________________________
Dizziness	_____	_____	______________________________
Difficulty swallowing	_____	_____	______________________________
***Heart:**			
Shortness of Breath	_____	_____	______________________________
Chest Pain	_____	_____	______________________________
Murmurs	_____	_____	______________________________
***Lungs:**			
Asthma	_____	_____	______________________________
Chronic Bronchitis	_____	_____	______________________________
Chronic Cough	_____	_____	______________________________
***GastroIntestinal:**			
Ulcers	_____	_____	______________________________
Nausea/vomiting	_____	_____	______________________________
Diarrhea/Constipation	_____	_____	______________________________
Ulcerative Colitis/Crohn's	_____	_____	______________________________
***Urinary:**			
Kidney stones	_____	_____	______________________________
Blood in urine	_____	_____	______________________________
Chronic Bladder/Kidney Infections	_____	_____	______________________________
***Spine:**			
Back/Leg Problems	_____	_____	______________________________
***Skin:**			
Psoriasis	_____	_____	______________________________
Eczema	_____	_____	______________________________

____

Signature Parent/Guardian Date

____

Signature Parent/Guardian Date

Subscribed to me on ________ day of _____________, 2016

____

Notary
Notary Public ________________________ County, Michigan

Acting in ____________________________ County, Michigan

My Commission Expires: ____________________________

All information provided in this document will be held strictly confidential.