METROPOLITIAN DETROIT YOUTH CHORUS
Medical Treatment Authorization
Effective September 1, _____(year) to August 31, _____(year)

_____ _____ _____
Chorus Member Legal Name Age Date of Birth

_____ _____ _____ _____
Address City State Zip Code

_____
Chorus Member Phone Number

CONTACT/INSURANCE INFORMATION:

_____ _____ Primary / Secondary
Parent /Guardian Contact # (circle one)

_____ _____ Primary / Secondary
Parent/Guardian Contact # (circle one)

_____ _____ _____
Other Emergency Contact Phone # Relationship to Member

_____ _____
Name of Physician Phone # of Physician

_____ _____
Insurance Carrier Policy #

_____ _____
Subscriber's Name Member #

(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, food sensitivities or medically based dietary restrictions. (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	_____	_____	_____

----------SIGNATURES BELOW ARE TO BE DONE BEFORE A NOTARY----------

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.

_____

Signature Parent/Guardian Date

_____

Signature Parent/Guardian Date

Subscribed to me on _____ day of _____ (month), _____(year)

_____

Notary (Signature & Print Name)

Notary Public _____ County, Michigan

Acting in _____ County, Michigan

My Commission Expires: _____

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