MJF Summer Jazz Camp
Participant Medical Form 2018

(To be filled out by camp staff)
Instrument ______________________
Tqqo "& Counselor __________ __________

Name ______________________ Date of birth ______________ Age ________ Male ☐ Female ☐
Address ______________________________ Grade completed (youth only) ________
City ______________ State ________ Zip ____________ Phone No. ______________
Health/accident insurance company ______________________ Policy No. ______________

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:
Name ______________________ Relationship ______________
Address ______________________________
Home phone ______________ Business phone ______________ Cell phone ______________
Alternate contact ______________________ Alternate's phone ______________

HEALTH HISTORY

Are you now, or have you ever been treated for any of the following:

Yes	No	Condition	If Yes, Please Explain
		Asthma Last attack: __________	
		Diabetes Last HbA1c: __________	
		Hypertension (high blood pressure)	
		Heart disease (e.g., CHF, CAD, MI)	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure: __________	
		Sleep disorders (e.g., sleep apnea)	Use CPAP: Yes ☐ No ☐
		Abdominal/digestive problems	
		Surgery	
		Serious injury	

Allergies or Reaction to:

Medication ______________________

Food, Plants, or Insect Bites ______________
____

Immunizations:

The following are recommended. **If** had disease, put "D" and the year. If immunized, check the box and the year received.

Yes	No	Date
☐	☐	**Tetanus** __________
☐	☐	Pertussis __________
☐	☐	Diphtheria __________
☐	☐	Measles __________
☐	☐	Mumps __________
☐	☐	Rubella __________
☐	☐	Polio __________
☐	☐	Chicken pox __________
☐	☐	Hepatitis A __________
☐	☐	Hepatitis B __________
☐	☐	Influenza __________
☐	☐	Other (i.e., HIB) __________

☐ Exemption to immunizations claimed (form required).

MEDICATIONS

List **all** medications taking--prescription medications as well as **over-the-counter medications. Include inhalers and Epi-Pens,** even if used only occasionally. Use back side of form for additional space if necessary. Please be sure to bring medications in sufficient amounts in original containers. **All Medications should be sent in a Ziploc bag labeled with student name in sufficient quantities for the two week camp and will be kept with the counselor during camp.** __________

Medication __________ Strength ________ Frequency ________ Approximate Date Started ________ Reason for medication ________ __________ __________	Medication __________ Strength ________ Frequency ________ Approximate Date started ________ Reason for medication ________ __________ __________	Medication __________ Strength ________ Frequency ________ Approximate Date started ________ Reason for medication ________ __________ __________
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In case of emergency involving the above participant, I understand that every effort will be made to contact the emergency contact(s) listed above. In the event that this person cannot be reached, permission is hereby given to MJF Summer Jazz Camp director, medical staff, and/or any health care provider to secure proper treatment, including hospitalization, surgery, or injections of medication needed for the above participant. Medical providers are authorized to disclose protected health information (PHI) including examination findings, test results, and treatment provided with camp staff for purposes of medical evaluation of the participant, follow-up and communication with the parent/guardian. I hereby release Monterey Jazz Festival from any and all claims or liability arising from participation in camp activities.

______________________ ______________
Parent/Guardian Signature Date

Full name: __________ DOB: __________ Allergies: __________ Emergency contact No.: __________