ACADEMY OF MUSIC

274 Main Street :: Northampton, MA :: 01060

Academy of Music Theater's 2012 Summer Musical Theatre Workshop Series

MEDICAL INFORMATION/RECORD OF IMMUNIZATION PARENTAL CONSENT FORM

This information is STRICTLY CONFIDENTIAL and is required for attendance in the 2012 Academy of Music Theatre Workshop Series. Return completed form to Debra J'Anthony, Executive Director, Academy of Music, 274 Main Street, Northampton, MA 01060. This form must be completed and returned no later than June 30, 2012

.

Part I:

Participant's Name ______________________________ **Date of Birth** ________________

Address ____

____

Home telephone number (____) ____

Parent's/Guardian's name ____

Parent's/Guardian's address (if different from above) ___________________________

____

City ______________________________ *State*____________ ZIP ____________

Parent's/Guardian's telephone (____)__________ Work Telephone (____) ______________

Cell number (_____)____________________ E-mail ______________________________

Parent's/Guardian's name ____

Parent's/Guardian's address (if different from above) ___________________________

____

City ______________________________ *State*____________ ZIP ____________

Parent's/Guardian's telephone (____)__________ Work Telephone (____) ______________

Cell number (_____)____________________ E-mail ______________________________

Name of another person to notify in case of emergency: ___________________________

Relationship ______________________ Telephone (____) ______________________

PERSONAL MEDICAL HISTORY

Give details and dates of all operations (including removal of tonsils, adenoids) None: ____________

____

____

2. IPV alone (injected Salk 4 doses) ___/___/___, ___/___/___, ___/___/___, ___/___/___ **(mm/dd/yy)**

3. IPV/OPV sequential IPV ___/___/___, IPV___/___/___, OPV___/___/___, OPV___/___/___ **(mm/dd/yy)**

MEASLES, MUMPS, RUBELLA DOCUMENTATION

*Two doses of measles, one dose each of mumps and rubella are required; either as trivalent vaccine or monovalent vaccine.

The first dose must be given on or after age 12 months, the second must be at least one month later.

**Or* laboratory evidence of immunity (positive titer)

M.M.R. first dose: ____/____/____ second dose ____/____/____ **(mm/dd/yy)**
or date of titer ____/___/___ Titer result _____________(attach copy of lab) **(mm/dd/yy)**

OR

MEASLES first dose dose ___/___/___ second dose ____/____/____ **(mm/dd/yy)**
or date of titer ___/___/___ Titer result__________________(attach copy of lab) **(mm/dd/yy)**

RUBELLA ____/____/____ **(mm/dd/yy)**
or date of titer ___/___/___ Titer result ____________(attach copy of lab) **(mm/dd/yy)**

MUMPS ____/____/____ (mm/dd/yy)
or date of titer ___/___/___ Titer result _______________(attach copy of lab) **(mm/dd/yy)**

VARICELLA

*History of disease yes_______ no ___________

*Varicella antibody ______/______/______ reactive __________ non-reactive _________ **(mm/dd/yy)**

*Immunization Dose #1 ____/____/_____, Dose #2 ____/____/____

M.D./N.P.'s signature____ Date___________________

Parent Signature ____

Date______________

Give details and dates of accidents, including dislocations, fractures, and any injury with loss of consciousness.
_______ None

____

____

Does student have any allergy to foods or drugs? ____Yes ____ No (If yes, please list)

____

____

Has student ever missed one or more terms from school because of illness? ____ Yes ____ No (If yes, please indicate the type of illness and provide dates)

____

____

Has student been under the care of a specialist (medical or mental health) in the past? ____ Yes ____ No (If yes, please indicate the type of illness and provide dates)

____

____

Does student have any chronic or congenital conditions? ____ Yes ____ No (If yes, please describe)

____

____

Does student take any medication? ____ Yes ____ No (If yes, please list)

____

____

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GIVE AGE(S) AT WHICH STUDENT HAS HAD ANY OF THE FOLLOWING:

____	Asthma	____	Eating disorder	____	Measles	____	Scarlet fever
____	Chicken Pox	____	German Measles	____	Mumps	____	Skin disorders
____	Colitis	____	Hay Fever	____	Nervous breakdown	____	Stomach Ulcer
____	Convulsions	____	Infectious mononucleosis	____	Pneumonia	____	Suicide attempt
____	Depression	____	Jaundice	____	Rheumatic fever	____	Tuberculosis
____	Diabetes	____	Malaria	____	Rheumatism or arthritis	____	Urinary Tract infection

WHERE APPROPRIATE, CIRCLE THE CONDITIONS OR SYMPTOMS THAT THE STUDENT HAS AND GIVE A BRIEF EXPLANATION.

Other diseases *(specify)* ____

Do you have ear trouble or defective hearing? ______________________________________

Do you have eye trouble or defective vision? Wear glasses? Contact lenses? ______________________

Do you have headaches, dizziness, seizures, or fainting spells? ______________________________

Do you have chest pain? Shortness of breath? Chronic cough? Wheezing? Heart murmur? __________
Heart trouble? ____

Do you have abdominal pain? Any gastrointestinal problems? Bowel trouble? Hemorrhoids or rectal trouble?
____

Do you have kidney trouble? ____

Do you have any endocrine (glandular) problems (e.g. diabetes, thyroid)?
If so, what medication are you taking? ______________________________________

Do you have pain or other trouble with your back, legs, feet, hands, or joints? ______________________

Has your weight changed by more than 10 pounds in the past six months? Gain? Loss? By how much? ___
Why? ____

Do you have any concerns about food? ______________________________________

HEALTH CARE PROVIDER AND INSURANCE INFORMATION

Participant's Health Care Provider____

Telephone (_____)________________________________

Participant's Insurance Provider____

Policy #________________________________ Telephone (____)________________________

PARENTAL CONSENT TO TREATMENT

We/I understand that our/my son/daughter, ____, has enrolled in the Academy of Music Theater Workshop Series, to be held July, 2011, at the Academy of Music, 274 Main Street, Northampton, Massachusetts. We do hereby request that the Academy of Music Theater Workshop Series do whatever steps necessary to secure medical treatment of our/my child named above in the event she appears to be in need of such treatment while attending the Academy of Music Theater Workshop Series to the rendering of all necessary treatment, including admission to a hospital or another appropriate health care facility, in such institutions and at such places as the Academy of Music Theater Workshop Series, acting through its agents, deems best. We/I authorize the agents or employees of the Academy of Music Theater Workshop Series to execute whatever forms might be necessary to ensure complete and adequate care of my/our child.

____

Signature of legally responsible parent or guardian Date

PART II: TO BE FILLED OUT BY STUDENT/FAMILY AND SIGNED BY A MEDICAL PROVIDER:

RECORD OF IMMUNIZATIONS/TESTS

Student Name ____

D.O.B. ____________________

REQUIRED:

Massachusetts' law and/or Academy of Music require the following immunizations or tests for *all* participating students. **You will not be able to participate in First Act! Summer Musical Theatre** Workshop **until this information has been provided. You must include the month,day and year, and this form must be signed and dated by a physician or nurse practitioner.**

TETANUS/DIPHTHERIA

*Primary series of 4 doses DTaP or DTP ____/____/____, _____/____/____, ____/____/____, ____/____/____

(mm/dd/yy)

***Td or Tdap** booster **(circle which vaccine used)** – must have been done within the last 10 years ____/____/____

(mm/dd/yy)

POLIO Primary series in childhood meets the requirement – fill in the dates according to the series you received

1. OPV alone (oral Sabin 3 doses) ___/___/___, ___/___/___, ___/___/___