

# Lawrence Academy of Music Health Form

Participant's Name: \_\_\_\_\_  
(Last) (First) (MI)

Home Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address if different than child: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address if different than child: \_\_\_\_\_

Name of Physician or Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Group Number \_\_\_\_\_

**Emergency Contact:**

Person to call in case of an emergency and parent/guardian is unable to be contacted:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Health information:**

Date of last Tetanus shot: \_\_\_\_\_

Special medical conditions and other medical information. Please include food allergies, medicines, insect bites/stings, asthma, diabetes, epilepsy, seizures, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Medical Treatment Consent for Minors**

If your child will be under age 18 while at Lawrence Academy of Music Camp, it is camp policy to secure your consent for medical treatment or medication distribution and for the use of medical devices.

Please initial the following:

\_\_\_\_I give permission for the camp nurse/head dorm counselor to administer medication prescribed by my child’s physician. All medications must be in a medicine bottle and labeled with the camper’s name, doctor’s name and phone number, medication name, and dosage. Also, please complete the following for each medication. Emergency medications such as inhalers, bee sting kits, or insulin may be kept with the student. All other medications will be stored by camp staff.

Name of medication: \_\_\_\_\_ Prescribing physician: \_\_\_\_\_

Physician’s Phone: \_\_\_\_\_ Days to be taken: \_\_\_\_\_

Dosage of medication \_\_\_\_\_ How is it taken? \_\_\_\_\_

When administered \_\_\_\_\_ Special Instructions: \_\_\_\_\_

.....  
Name of medication: \_\_\_\_\_ Prescribing physician: \_\_\_\_\_

Physician’s Phone: \_\_\_\_\_ Days to be taken: \_\_\_\_\_

Dosage of medication \_\_\_\_\_ How is it taken? \_\_\_\_\_

When administered \_\_\_\_\_ Special Instructions: \_\_\_\_\_

.....  
Name of medication: \_\_\_\_\_ Prescribing physician: \_\_\_\_\_

Physician’s Phone: \_\_\_\_\_ Days to be taken: \_\_\_\_\_

Dosage of medication \_\_\_\_\_ How is it taken? \_\_\_\_\_

When administered \_\_\_\_\_ Special Instructions: \_\_\_\_\_

.....  
Name of medication: \_\_\_\_\_ Prescribing physician: \_\_\_\_\_

Physician’s Phone: \_\_\_\_\_ Days to be taken: \_\_\_\_\_

Dosage of medication \_\_\_\_\_ How is it taken? \_\_\_\_\_

When administered \_\_\_\_\_ Special Instructions: \_\_\_\_\_

\_\_\_\_I hereby give permission for the camp nurse/head dorm counselor to administer aspirin or an aspirin substitute to my child.

\_\_\_\_I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child in the event of a medical situation occurring during my absence or when the hospital physician(s) are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel within the hospital as well as any physician where treatment is rendered in the physician’s office. I release from medical responsibility and liability, the hospital, medical authorities, and physicians for performing medical procedures acting on the authority of this medical treatment consent form that are deemed necessary for my minor child.

Minor Child’s Name: \_\_\_\_\_

Signature of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_