



2017 MEDICAL INFORMATION FORM

Member Name: _____ Date of Birth: _____
(Please include middle initial)

Email Address: _____ Cell Phone: _____

Primary Parent/Guardian #1 Name: _____ Phone: _____
(Please include middle initial)

Address: _____ City State: _____ Zip: _____

Email Address: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian #2 Name: _____ Phone: _____
(Please include middle initial)

Address: _____ City State: _____ Zip: _____

Email Address: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Information
(Other than the people listed above if possible)

Name: _____ Relation: _____ Phone: _____

Insurance/Physician Information

Person Carrying Insurance: _____ Relation: _____

Doctor's Name: _____ Office Phone: _____

Insurance Provider: _____ Group #: _____ ID #: _____

Special Instructions on Insurance: _____

**** All medications must be registered on this form ****

Do you have any medical issues that have or may prevent you from participating in rehearsals, performances, or tour activities that the Oregon Crusaders should be aware of? Yes No If yes, please explain:

Are you required to take any prescribed medication on a regular basis? Yes No

If yes, please list prescriptions and regularity: _____

It is the member's responsibility to provide their own prescription and non-prescription medications, wraps, braces, etc. that may be of normal use for them. Some prescription medications should be given to a designated staff member for distribution as required such as narcotics, ADHD medications that are known for their high levels of abuse or theft. Any rescue medications such as Epi Pens® and inhalers should be on the participant at all times.

Please sign to grant permission to the Oregon Crusaders to give non-prescription medication to you in case of an emergency or injury:

Do you have any allergies (including FOOD, medications, etc)? Yes No If yes, please explain:



Participation Consent and Release, Liability Waiver, and Indemnity Agreement

In consideration for participation of the undersigned participant in the Oregon Crusaders Drum and Bugle Corps program(s) ("Corps"), we, the undersigned, with the intent to be legally bound, do for ourselves, our heirs, executors, administrators and all others claiming by, or through us, do hereby state that we consent to the participant's participation in the Corps' activities. We are aware of all risks, hazards, and uncertainties connected with participation in the programs and activities of the Corps.

We hereby waive, release, and discharge the Corps and all of its officers, directors, officials, instructors, employees, volunteers, and any other individuals acting for or on behalf of the Corps, from any and all claims while participating in, traveling to or from, or competing in any of the activities or functions of the Corps. It is our specific intent to release, acquit, and forever discharge the Corps, all of its officers, directors, officials, instructors, employees, volunteers, and any other individuals acting for or on behalf of the corps from all claims, demands, actions, causes of action and from all liability for injury, damage or loss of whatsoever kind, nature or description that may arise or be sustained by the participant which is due or in any way connected with the participant's participation in the Corps or any of its functions or activities. It is further our specific intent that this release applies to any injury, damage, or claim arising from any act or omission of the Corps or any of the individuals released hereby including any injury, damage, or claim arising from any negligent act or negligent omission of the Corps or individuals released hereby.

The participant and the undersigned hereby assume full responsibility for all risk of bodily injury, death, or property damage due to the negligence or other conduct of those parties released hereby or otherwise, as a result of any activities connected in any way with the Corps. The undersigned and participant on behalf of themselves and all of their heirs, executors and administrators and all others do hereby further agree not to sue the Corps or any of the individuals released hereby in the event of any injury or damage of any kind or description whatsoever. This includes any claim, demand, or suit by the minor participant either before he or she reaches the age of majority or thereafter.

The undersigned further agree to indemnify and hold the Corps, and all of those individuals released hereby, completely and absolutely harmless from all expenses, demands, claims, fees and costs of whatsoever description or nature which may arise as the result of any such claims being instituted any time. This includes all costs, fees, and expenses involved in defending or investigating any and all claims, demands, or causes of action whatsoever that may hereafter be asserted or brought by the participant or anyone on his or her behalf for the purpose of enforcing any claim for damages sustained during participation in any of the activities of the Corps.

Emergency Medical Authorization

I (We), the undersigned, do hereby consent and authorize any duly authorized doctor, emergency medical technician, hospital or other medical facility to treat or attempt to treat the participant for any injuries received by said participant while he or she participates in any activity of the Corps. I (We) further authorize any licensed physician to perform any procedure that he or she deems advisable in attempting to relieve or treat any injuries or any related unhealthy condition in said participant that might be encountered during any necessary procedure or operation. I (We) further consent to the administration of any anesthesia as deemed advisable by any licensed physician, and do hereby further authorize any x-ray examination, medical or surgical diagnosis or treatment, and hospital care to be rendered to the participant under the general or special supervision and on the advice of a licensed physician, surgeon, anesthesiologist, dentist or other qualified personnel acting under their supervision.

In the event of an emergency where blood products are recommended, I (We) Do _____ or Do Not _____ give our authorization.

I (We), the undersigned, realize and appreciate that there is a possibility of complication and unforeseen consequences in any medical treatment, and we assume any such risk on behalf of ourselves and the participant as stated herein. I (We) acknowledge that there has been no warranty made as to the results of any such treatment or diagnostic procedure. Any medical or prescription costs not covered by insurance are the sole responsibility of the undersigned. Any medical or prescription costs will be paid over the phone at the time(s) of service to the provider. If this is not possible, all payments made by a Corps Representative will be billed to the member to be reimbursed to the Corps upon receipt.

Each of the undersigned expressly acknowledges and agrees that they have read and understood the terms of this form. And they further state that no oral representations, statements, or inducements apart from the foregoing written provisions have been made. All personal information provided by undersigned in this form is said to be true to the best of their knowledge.

YES___ NO___ I (We) give permission for the Oregon Crusaders staff to talk to parents/guardians and medical professionals (doctors, nurses, therapists, etc.) about my medical/psychological status if such need arises (i.e. emergency, unconsciousness).

I (WE) HAVE READ, UNDERSTOOD, AND VOLUNTARILY SIGNED THIS RELEASE

(Participant) Date _____

Parent/Guardian Signature (if member under 18) Date _____

*** This form is in effect from date signed through September 1, 2017 ***

Turn in all complete forms at a camp or send to Nicole Moyo at nicole@oregoncrusaders.org



2017 Health History Form (page 1)

Member Information:

Name _____ Sex _____ Date of Birth _____ Height _____
Weight _____ All Allergies (Food/Medication/Etc.) _____

Please answer all questions.

- | | YES | NO | |
|-----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a medical illness or injury since your last check up or sports physical? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have an ongoing or chronic illness?
If so, please list: |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized overnight?
If so, when and what for? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery?
If so, when and what for? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking or using any prescription, non-prescription (over-the-counter) medications, vitamins, supplements or any medications used for weight loss or performance enhancement? If so, please complete medication form. |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have or use any medication used for emergencies such as a rescue inhaler or EpiPen®? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever passed out during or after exercise? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been dizzy during or after exercise? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chest pain during or after exercise? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Do you get tired more quickly than your friends during exercise? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had racing of your heart or skipped heartbeats? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had high blood pressure or cholesterol? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been told you have a heart murmur? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Have any family members or relatives died of heart problems or of sudden death before age 50? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Has a physician ever denied or restricted your participation in sports for ANY heart problem for any reason such as anemia, blood clots, pulmonary issues, etc.? |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any current skin problems (for example, itching, rash, acne, warts, fungus, or blisters)? |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a head injury or concussion? If so, when and how many? |

2017 Health History Form (page 2)

- | YES | NO | |
|-----|--------------------------|---|
| 19. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been knocked out, become unconscious, or lost your memory? |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a seizure?
If so, when and when was your last seizure? |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a numbness or tingling in your arms, hands, or feet? |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a stinger, burner, or pinched nerve? |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever become ill from exercising in the heat? |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> Do you cough, wheeze, or have trouble breathing during or after activity? |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> Do you have asthma?
If so, please attach your asthma action plan |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> Do you have seasonal allergies requiring medical treatment?
If so, please complete medication form |
| 27. | <input type="checkbox"/> | <input type="checkbox"/> Do you use any special protective devices (for example, a knee brace)? |
| 28. | <input type="checkbox"/> | <input type="checkbox"/> Have you had any problems with your eyes or vision? |
| 29. | <input type="checkbox"/> | <input type="checkbox"/> Do you wear glasses or contacts? |
| 30. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had a sprain, fracture, or dislocation of a muscle, tendon, bone or joint?
If yes, check appropriate box and explain |
| | <input type="checkbox"/> | Head |
| | <input type="checkbox"/> | Neck |
| | <input type="checkbox"/> | Back |
| | <input type="checkbox"/> | Chest |
| | <input type="checkbox"/> | Shoulder |
| | <input type="checkbox"/> | Upper Arm |
| | <input type="checkbox"/> | Elbow |
| | <input type="checkbox"/> | Forearm |
| | <input type="checkbox"/> | Wrist |
| | <input type="checkbox"/> | Hand |
| | <input type="checkbox"/> | Finger |
| | <input type="checkbox"/> | Hip |
| | <input type="checkbox"/> | Thigh |
| | <input type="checkbox"/> | Knee |
| | <input type="checkbox"/> | Shin/Calf |
| | <input type="checkbox"/> | Ankle |
| | <input type="checkbox"/> | Foot |
| 31. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been diagnosed with a mental illness? If so, what? |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> Are you currently on medications for depression, anxiety or ADD/ADHD or any other possible mental illness? If so what and how long?
<hr/> |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> Have you ever had suicidal thoughts, homicidal thoughts or attempted suicide? |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> Do you consider yourself mentally stable at this time? |