



# International School of Music

South Campus: 5110 Ridgefield Rd. #104, Bethesda MD 20816 Tel:301-657-0763 Fax: 240-396-5757  
North Campus: 10450 Auto Park Ave, Bethesda MD 20817 Tel:301-365-5888 www.ismw.org info@ismw.org

## Camper's Health and Information Form

### PARTICIPANT'S INFORMATION

Please complete this form and **bring it by June 1<sup>st</sup>, 2010**. Be sure all medical and immunization forms are attached.

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Parent/ Guardian Name \_\_\_\_\_ Child: \_\_\_\_\_ Male \_\_\_\_\_ Female

Address \_\_\_\_\_

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

Emergency contacts (someone other than parent/guardian)

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ Cell \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ Cell \_\_\_\_\_

Hospital of Choice (in case of emergency): \_\_\_\_\_

### IMMUNIZATION REQUIREMENTS

All children who attend the International School of Music camps must have current immunizations that are consistent with State of Maryland school requirements.

\_\_\_ My child is registered at a Maryland licensed school or day care as follows: \_\_\_\_\_

(Note: Attending a licensed public or private school or day care in the state of Maryland verifies immunization.)

**A Maryland Immunization Certificate must be attached if your child is not registered in a school or day care in the state of Maryland.**

### HEALTH INFORMATION

- Date of last Tetanus shot: \_\_\_\_\_ (must be completed for child to attend)
  - Are there any identified health issues (including but not limited to asthma, diabetes and epilepsy) that may need emergency treatment? \_\_\_ NO \_\_\_ YES ( If yes, please provide physician's statement)
  - Does your child require medication during the program hours? \_\_\_ NO \_\_\_ YES
  - **An Authorization for Medication form must be attached if your child must receive medication during program hours. Please let all medications and dosages.**
- Medications** \_\_\_\_\_
- \_\_\_\_\_

- Please list any and all allergies
- \_\_\_\_\_
- \_\_\_\_\_

- To help us serve your child better, does your child have any health problem(s) including physical, psychiatric, behavioral, or other problems. Please be specific.

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**Health History** (All information provided will be kept confidential)

Describe allergies, details of chronic conditions, or health restrictions on additional sheet if needed.

Are all immunizations up to date? \_\_\_ Yes \_\_\_ No

If no, please state reason: \_\_\_\_\_

Please provide comments where applicable: Medication being taken: \_\_\_\_\_

Specific information including physical, psychiatric or behavioral problems:

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Please check where applicable and explain:

\_\_\_ Allergies: \_\_\_\_\_

\_\_\_ Asthma: \_\_\_\_\_

\_\_\_ Other health issues that the camp needs to be aware of: \_\_\_\_\_

\_\_\_ Medications: \_\_\_\_\_

**Health Insurance Company Information:**

Company Name (Medical Insurance): \_\_\_\_\_

Policy Holder's Name (Provider): \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth \_\_\_\_\_ Parent cell phone \_\_\_\_\_

**Registration Release Statement**

*The participant assumes all risks associated with participation in the program. The School and Instructors assume NO liability for injury or damages arising from participation in the program. The participant also consents to use of photographs or video tapes by the International School of Music for marketing purposes. The participant agrees to emergency treatment if needed. If the participant is a minor, the parent/guardian approves of his or her participation in the program. By signing here, I verify that all the information on this form is correct and accurate, and I agree to the release statement.*

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

**Permission for Emergency Medical Treatment**

In case of a medical emergency or serious illness, and in the event that the parent/guardian cannot be immediately contacted I hereby authorize the ISM staff to call the Physician indicated on this form and follow his or her instructions. If the physician can not be contacted, I consent to emergency medical treatment for our child and we assume liability for any expenses incurred in such an emergency (transportation, hospitalization, x-rays, etc), medical expenses incurred.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** If your child does not attend school in Montgomery County, then a copy of your child's complete immunization records must be provided to ISM by law.