Medical History

Please answer the following questions as carefully and accurately as possible. This form is for use only in the event of a medical emergency. Information provided will be kept *strictly* confidential.

1. Have you received the COVID Vaccine? YES NO

   Dates Vaccination received if applicable

   _____

2. Do you have asthma? YES NO

3. Do you have any type of heart conditions that requires you to take medications or that involves any restrictions? YES NO

4. Do you have diabetes? YES NO

5. Do you have any allergies? YES NO

   Please list allergies: _____

6. Do you have any medication allergies? YES NO

   Please list allergies: _____

7. Have you ever been diagnosed with an eating disorder? YES NO

   Please explain: _____

8. Do you wear contacts or glasses? YES NO

9. Do you have any problems with joint or muscles? YES NO

10. List all hospital admissions including operations, serious illnesses (include Chicken Pox) and severe injuries. Please date:

_____

_____

_____

_____

_____

_____

11. Height: _____ Weight: _____

Immunizations: OPV: 1. _____ 2. _____ 3. _____ 4. _____
(please give dates) DPT: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
MMR:1. _____ 2. _____
Other (i.e. Hepatitis)1. _____ 2. _____ _____

Mohawk Valley Performing Arts Medical Release Form

Dancer's name: _____
(last name) *(first name)* *(M.I.)*
Date of birth: _____(MM/DD/YYYY) Sex: _____ (M/F)
Father's name (or guardian): _____
Mother's name (or guardian): _____
Home mailing address: _____
(# street, P O Box, town or city, state and zip code)
Home phone _____ Father's work no. _____
Cell phone _____Mother's work no. _____
Medical insurance: _____Subscriber acct #: _____
In case of an emergency and neither parent can be reached contact:

Name: _____ Relationship to dancer: _____
Address: _____
Phone #(s): _____
Physician's name: _____ Phone: _____
Preferred hospital: _____

Please read and sign: In case of emergency I consent for emergency room physician or nearby provider to perform any treatment deemed necessary.

Signature of custodial parent or legal guardian: _____
Date: _____