

Boston University Bands  
855 Commonwealth Ave  
Boston, MA 02215  
617-358-BAND



**Medical Authorization**

Boston University Bands students and their parents must agree to the conditions set forth below prior to the student's arrival on campus. **Please print.**

Student's full name \_\_\_\_\_  
last first middle initial

Social Security no. \_\_\_\_\_ Date of birth (mm/dd/yy) \_\_\_\_\_

Home address \_\_\_\_\_  
street  
\_\_\_\_\_  
city state zip country

Parent's name \_\_\_\_\_  
last first middle initial

Physicians, nurse practitioners, nurses, and other professional staff employed at any medical facility to which the Boston University Bands may refer the student are authorized to perform examinations and prescribe and render treatment when consulted by the student. No surgical procedure will be undertaken upon a minor child (under age 18) without prior consent of the parent except in case of emergency.

When, in the judgment of the physician, a condition exists which should be reported to the parent of a minor child, the parent may be notified after informing the student of the plan to notify the parent. Boston University Bands and any medical facility to which the student may be referred may release medical information or a copy of a minor child's medical record to the child's parent, upon appropriate written request by the parent.

All medical costs incurred including, but not limited to, ambulance charges, pharmacy costs, hospital emergency room visits, x-rays, laboratory tests, etc., are the financial responsibility of the parent and/or student. If you have medical insurance, you are advised to contact your insurance company for its policies on out-of-area coverage. Students should carry an insurance card (or a photocopy of an insurance card) with them. **Please provide your medical insurance information requested below and attach a photocopy of the front and back of your insurance card in the spaces provided.**

Name of insurance company \_\_\_\_\_ Policy number \_\_\_\_\_

Address \_\_\_\_\_ Policy holder \_\_\_\_\_

Pertinent medical information including known allergies and medical conditions which might affect treatment have been disclosed on the *Report of Medical History* (on reverse side of this authorization), which will be maintained in the files of the staff employed by the Boston University Bands.

It is understood that the University assumes no responsibility for providing and/or referring students to medical care in the event the student and/or parent chooses to seek such care independently.

The undersigned hereby acknowledge the above conditions and agree to abide by them during the period the student is enrolled in Atlantic Brass Quintet Seminar, sponsored by Boston University Bands, in July/August 2008

Student's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

## Report of Medical History

**Please print.**

Student's name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 (mm/dd/yy) \_\_\_\_\_

Parent's name \_\_\_\_\_  
last first middle initial

Home telephone (\_\_\_\_\_) \_\_\_\_\_ Other telephone (e.g., cell, business) (\_\_\_\_\_) \_\_\_\_\_

In case of emergency, alternate contact \_\_\_\_\_  
last name first name

Home telephone (\_\_\_\_\_) \_\_\_\_\_ Other telephone (e.g., cell, business) (\_\_\_\_\_) \_\_\_\_\_

Name of student's physician \_\_\_\_\_

Physician's telephone (\_\_\_\_\_) \_\_\_\_\_  
last first

CHECK if you have had any of the following **(comment on all checked conditions in the space below):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> Insomnia                      | <input type="checkbox"/> Pain/pressure in chest       |
| <input type="checkbox"/> Dizziness, fainting       | <input type="checkbox"/> Weakness, paralysis           | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Measles                   | <input type="checkbox"/> Emotional problems            | <input type="checkbox"/> Chronic cough                |
| <input type="checkbox"/> German Measles            | <input type="checkbox"/> Eating disorder               | <input type="checkbox"/> Palpitations (heart)         |
| <input type="checkbox"/> Mumps                     | (Anorexia, Bulimia)                                    | <input type="checkbox"/> High or low blood pressure   |
| <input type="checkbox"/> Chicken Pox               | <input type="checkbox"/> Recurrent headaches, colds    | <input type="checkbox"/> Rheumatic Fever or           |
| <input type="checkbox"/> Malaria                   | <input type="checkbox"/> Mitral Valve Prolapse         | Heart murmur  |
| <input type="checkbox"/> Sinusitis                 | <input type="checkbox"/> Head injury with              | <input type="checkbox"/> Disease or Injury of joints  |
| <input type="checkbox"/> Gum/tooth trouble         | unconsciousness  | <input type="checkbox"/> "Trick" knee/shoulder, etc.  |
| <input type="checkbox"/> Eye trouble               | <input type="checkbox"/> Tuberculosis                  | <input type="checkbox"/> Back problems                |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Stomach or intestinal trouble | <input type="checkbox"/> Gallbladder trouble or       |
| Gallstones   |  |   |
| <input type="checkbox"/> Ear, nose, throat trouble | <input type="checkbox"/> Shortness of breath           | <input type="checkbox"/> Tumor, cancer, cyst          |
| <input type="checkbox"/> Recurrent diarrhea        | <input type="checkbox"/> Rupture, Hernia               | <input type="checkbox"/> Recent weight gain/loss      |
| <input type="checkbox"/> Herpes                    | <input type="checkbox"/> Albumin/sugar in urine        | <input type="checkbox"/> Urinary tract infection      |
| <input type="checkbox"/> Surgery                   | <input type="checkbox"/> Allergy                       | <input type="checkbox"/> Convulsions or epilepsy      |
| ___Appendectomy                                    | ___Penicillin  | <input type="checkbox"/> Loss of consciousness        |
| ___Tonsillectomy                                   | ___Sulfonamides  | <input type="checkbox"/> Gynecological problems       |
| ___Hernia repair                                   | ___Other medications                                   | (Females only-explain                                 |
| below.)  |  |   |
| ___Other   | ___Foods (which)                                       |   |
| <input type="checkbox"/> Hay fever/asthma          | ___Other (list below)                                  |   |

OTHER RELEVANT CONDITIONS:

- Has your physical activity been restricted during the past five years? (Give reasons and duration.)
- Have you had any illness or injury or been hospitalized other than already noted? (Give details.)
- Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years? (Other than routine checkups?)
- Have you consulted or been treated by a psychiatrist or clinical psychologist?
- Have you ever had a positive skin test for tuberculosis (T.B.)? If yes, when and what was done about it?
- Are you taking any medications? (List below)**

HOSPITALIZATIONS / REMARKS / ADDITIONAL INFORMATION

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IMMUNIZATION HISTORY (Please enter dates - mm/dd/yy)

Tetanus booster \_\_\_\_\_ Tuberculin test (mantoux) \_\_\_\_\_ Varicella Vaccine \_\_\_\_\_

Measles/Mumps/Rubella #1 \_\_\_\_\_ Measles/Mumps/Rubella #2 \_\_\_\_\_

**Medical Insurance Information**

Student's name \_\_\_\_\_ Date of birth (mm/dd/yy) \_\_\_\_\_  
last first middle initial

Please place photocopies of the front and back of your medical insurance card in the spaces below.

