

# Indiana Choral Directors Association 2020 All-State Jazz Choir Medical Form

**All-State Members...Please mail or scan and email to Mrs. Buchanan once you have accepted your spot! [buchananbr@clay.k12.in.us](mailto:buchananbr@clay.k12.in.us)**

This form is to be completed by the parent/legal guardian of the participant. Thank you for printing clearly.

Participant's Name \_\_\_\_\_ Age \_\_\_\_\_

Participant's Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Comments, special problems, allergies, daily medications (over the counter and prescription – include dosage directions)

\_\_\_\_\_

Parent/Legal Guardian's Name \_\_\_\_\_ Phone # H (\_\_\_\_) \_\_\_\_\_

W# (\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone # (\_\_\_\_) \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Group or Policy Number \_\_\_\_\_

In case of emergency, please list the name and phone number of those people who should be contacted, in the order in which they should be contacted.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_ has my permission to receive medical attention in the event of illness or medical emergency while participating in the ICDA All-State Jazz Choir weekend during the period of \_\_\_\_\_. I will assume financial responsibility for any cost of health care for my child that may occur while participating in the ICDA All-State Jazz Choir (rehearsals, performances, and the overnight stay).

\_\_\_\_\_

Date

Parent/Legal Guardian Signature