

MEDICAL FORM

Student Name: _____ SS #: _____ Date of Birth: ____/____/____
Home Address: _____ City: _____ State: ____ Zip: _____
Parent/Guardian Name: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Emergency Contact Name: _____ Relationship to Student: _____
Emergency Contact Home Phone: (____) _____ Cell Phone: (____) _____

To be completed and signed by all students and by parents/guardians of students

I certify that _____ is able to participate, and that there is no objection to his or her participation, in the New England Youth Wind Ensemble and/or Junior Wind Ensemble (NEYWE), or any of the activities therein contained. Furthermore, in consideration of my child's being permitted to participate in the UMass Lowell's NEYWE programs, I agree, on behalf of my child, myself, my family, heirs and personal representatives to assume all risks and responsibilities surrounding my / my child's participation in UMass Lowell's New England Youth Wind Ensemble and/or Junior Wind Ensemble program. To the maximum extent permitted by law, I release and indemnify the University of Massachusetts Lowell, its Board of trustees and their officers, employees, and agents, from and against any present or future claim, loss or liability for injury to person or property which I or my child may be liable to any other person, during my / my child's participation in UMass Lowell's New England Youth Wind Ensemble and/or Junior Wind Ensemble program - held at the University from Wednesday, January 21 through Friday, May 1, 2015.

In the event that it becomes necessary to seek medical attention or to go to a hospital, you have my permission to seek such help as may be determined necessary by the Director or the Program Staff. A child taken to the hospital will necessitate parents/legal guardians attendance at the hospital at the earliest possible time.

Emergency Care Providers require the following information. All information provided shall be held in confidence and maintained by the Director and Administrative Staff.

My / Our Medical Plan is: _____ Medical Plan Number: _____
The Policy Holder is: _____ Employer of Policy Holder: _____
Primary Care Doctor: _____ Primary Care Phone: (____) _____
Location of Primary Care Doctor: _____ No Medical Insurance: _____
Does your insurance provider require notification prior to emergency care? Circle One Yes / No

Signature of Student: _____ Date: _____
Signature of Parent / Guardian: _____ Date: _____

Please list ALL of the following: *Current Medical Conditions, Allergies, Current Medications, for what purpose is medication being taken, any physical limitations* that would prevent you from participating fully in UMass Lowell's New England Youth Wind Ensemble/Junior Wind Ensemble. *Please be specific.* Please attach any necessary information.