LUTHERAN SUMMER MUSIC ACADEMY & FESTIVAL

MEDICAL INFORMATION

Return by May 15, 2017 to:
Lutheran Music Program
122 W Franklin Ave, Suite 230
Minneapolis, MN 55404

Student Name____ Date of Birth _________________

Please complete this form. Print clearly and copy for your own records. All health information will be kept confidential in accordance with federal HPPA regulations.

Notice Concerning Treatment
Only qualified health care professionals can recommend medication and/or treatment. Professionals at the Porter Regional Hospital and Clinics are available for medical care of any kind. To facilitate urgent care, should it become necessary, please complete the enclosed Porter Regional Health Center Form, listing all medical insurance information. This form will accompany students in the event medical care is needed.

Consent for Treatment of Minor
I hereby authorize the care of the above named minor, which in the opinion of the attending health care provider, requires diagnostic and/or medical treatment. This release form is for the sole purpose of authorizing medical treatment in the absence of a parent or guardian and **expires on July 23, 2017.**

Medical Treatment
Lutheran Summer Music Academy & Festival contracts for emergency medical insurance for all academy students. Benefits are provided for accident or illness that manifests itself during the period of June 25 - July 23, 2017 and is not covered by the student's insurance carrier. Benefits are not provided for pre-existing conditions, interpreted as conditions for which the individual is presently receiving treatment or has been advised to receive treatment within the past two years.

I do hereby authorize Lutheran Summer Music Academy & Festival or its representatives to obtain professional urgent or emergency medical treatment for my son or daughter and I agree to pay the cost of all such treatment not covered by my insurance carrier or by academy emergency medical insurance in the event such treatment becomes necessary.

Parent / Guardian's Signature: ____ Date: ___________

Parent / Guardian's Name (print): ____

Address: ____

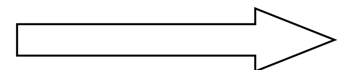
Parent / Guardian Contact Phone: ____ ❑ Cell ❑Other

Emergency Contact in Absence of Parent:

Name ____ Relationship to Student ________________________

Phone Number ____ ❑ Cell ❑ Other

PLEASE COMPLETE THE OTHER SIDE, LISTING ALL MEDICATIONS YOU WILL BE SENDING WITH YOUR SON/DAUGHTER, INCLUDING OVER-THE-COUNTER MEDICATIONS. IF MEDICATIONS CHANGE AFTER SUBMITTING THIS FORM, PLEASE INCLUDE A NOTE WITH YOUR SIGNATURE FOR LSM REGISTRATION OUTLINING THOSE CHANGES.



DO NOT FAX

Medication
All prescription and nonprescription medications, including vitamins, will be collected at registration are kept in a secure location in the LSM Infirmary and dispensed by the LSM Nurse. Provide written instructions for the administration of prescription medication. Academy staff members may assist in administering medication only with written instructions and explicit permission from a parent or guardian. Students found in possession of any over-the-counter or prescription medications without prior permission from the LSM Nurse will be subject to immediate disciplinary action by the Executive DIrector.

I authorize the LSM Nurse to dispense the following prescription and non-prescription medications to my son/daughter according to the following instructions:

Prescription	Medication (As listed on bottle.)	Dosage	Time of Day	Reason for Taking	Additional Instructions
__ Prescription __ Nonprescription			__ Breakfast __ Lunch __ Dinner __ Bedtime __ As Needed		
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__ Prescription __ Nonprescription			__ Breakfast __ Lunch __ Dinner __ Bedtime __ As Needed		

Non Prescription Acetaminophen
The LSM Nurse will dispense Acetaminophen (Tylenol) at his/her discretion and will have it stocked in the infirmary. Please mark the box below to give the LSM Nurse permission to dispense to your son/daughter. ALL other discretionary medications will need to be sent with the student or mailed during the academy.

❑ **I give the Academy Nurse permission to dispense Acetaminophen and understand that no other over the counter medications will be available, other than those that I send with my son/daughter.** Parent Initials ______

General Medical Information
So that your son/daughter's experience at the 2017 academy is as safe and enjoyable as possible, please fully disclose all relevant safety and health information, including emotional, dietary, or medical needs. All student health information is kept in a secure location and will be kept confidential in accordance with federal patient privacy laws (HPPA).
Immunizations Current: __ Yes ___ No If no, please describe: **Date of last tetanus injection:**__________
Check any of the following which apply at the present time:

- □ Diabetes
- □ Epilepsy
- □ Heart Condition
- □ Concussion / Head Injury
- □ Physical handicap
- □ Asthma or Lung Condition
- □ Any contagious disease or recent exposure (identify):
- □ Anxiety or Depression
- □ Behavioral disorders (e.g., ADD, ADHD, Asperger syndrome, autism) *Circle those that apply.*
- □ Allergies / Check here if sending an Epi-pen _____
- □ HIV / AIDS
- □ Special dietary restrictions:__________________________
- □ Other

Describe condition(s) and current treatment for all boxes checked above:

Please list (or attach) any medical concerns you have about your son/daughter:

DO NOT FAX