COLTS YOUTH ORGANIZATION MEDICAL RELEASE FORM

VOLUNTEERS & STAFF *RETURN TO colts@colts.org; 2300 Twin Valley Drive, Dubuque, IA 52003; or Fax 844-347-5323*

Name_____ Cell Phone_____

Sex Assigned at Birth_____ Gender Identity_____

Birthdate_____ Email_____

Address_____ City, State, Zip_____

Please answer **all** questions by circling "YES" or "NO":

1.	Have you ever had or been diagnosed with a heat related illness?	YES	NO
2.	Have you ever been dizzy or passed out during exercise?	YES	NO
3.	Have you ever had chest pain during or after exercise?	YES	NO
4.	Do you have high or low blood pressure?	YES	NO
5.	Have you ever had a seizure?	YES	NO
6.	Have you ever had problems with your vision or eyes?	YES	NO
7.	Do you wear glasses, contacts, or protective eyewear?	YES	NO
8.	Do you have any chronic medical conditions that might affect your ability to volunteer or be of concern (ex: heart disease, diabetes, seizures, asthma, etc.)? If YES, please describe: _____ _____	YES	NO
9.	Are you currently under the care of a physician? If YES, please explain:_____ _____	YES	NO
10.	Are you using prescribed medications? If yes, please list prescription(s) and use: _____ _____	YES	NO

MEDICINE ALLERGIES: Please list medications you are ALLERGIC TO here – please be specific:

_____

OTHER ALLERGIES: Please list any other allergies here:

_____

OTHER MEDICATIONS: Please list other medications you USE here – please be specific:

_____

_____

MEAL PLAN/FOOD ALLERGIES – We offer two meal options, Standard and Vegetarian. Please list food allergies or sensitivities here (even if noted above, including dairy, soy, gluten, etc): _____

Please check here if you desire a vegetarian meal plan on tour: _____

EMERGENCY CONTACT

Name_____ Relationship_____

Cell Phone_____ Email_____

Address _____ City/State/Zip_____

MEDICAL INSURANCE

Policyholder Name_____ Insurance Name_____

Policy/Plan Number _____ Group Number _____

Policyholder Birthdate_____ Is this a (please circle): HMO PPO Other:_____

Insurance Phone_____ Insurance Website_____

Primary Physician name _____ Coverage Out of State? Yes No

Are you currently under the care of a specialist? (Y/N) _____ If yes, please note specialist, contact information, and any other detail here:_____

_____

COVID-19

Were you ever diagnosed with COVID-19 infection? Circle one: Yes No

- If yes, did you have symptoms with COVID-19 that were moderate or severe (ex.: shortness of breath, exercise intolerance, chest tightness, dizziness, syncope, or palpitations)? Circle One: Yes No
- If yes, did you need to be hospitalized due to COVID-19? Circle One: Yes No

COVID-19 Vaccine Type: Moderna_____ Pfizer_____ Johnson & Johnson_____ NONE_____

Date(s) Received:_____ _____

Booster? Yes No

- If yes, please note Booster Type: Moderna_____ Pfizer_____ Johnson & Johnson_____
- If yes, please specify Date Received: _____

COVID-19 & GENERAL RELEASE

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions the Colts Youth Organization ("Colts") adheres to comply. In consideration of my participation in activities with the Colts, the undersigned acknowledge and agree to the following:

- I fully understand the contagious nature of COVID-19 and that the CDC and many other public health authorities recommend practicing social distancing and wearing face coverings while in public spaces.
- I further acknowledge that prevention of the spread of the COVID-19 is a shared responsibility by all.
- I further acknowledge the Colts have put in place preventative measures to reduce spread of COVID-19.
- I further acknowledge that the Colts cannot guarantee I will not become infected with COVID-19. I understand the risk of becoming exposed to and/or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Colts staff, volunteers, and other students and their families.
- While no activity is completely risk-free, I voluntarily chose to participate in Colts activities and acknowledge that I may increase my exposure risk to COVID-19. I acknowledge that I must comply with all set preventative procedures to reduce potential spread while participating in Colts activities.
- I further acknowledge the COVID-19 vaccine and testing is an expected condition of inclusion in Colts activities.

To do my part to limit the exposure to and/or transmission of COVID-19 to myself and those around me I agree to adhere to the recommendations of the CDC, including:

- Proper and frequent hand washing techniques & Use of hand sanitizer when handwashing is unavailable.
- **Proper** use of personal protective equipment (such as gloves, masks, or bell covers), including wearing a cloth face covering if indicated.
- Maintaining 6 feet of distance between people whenever possible.
- Not sharing any personal items (towels, clothes, water bottles, lip balm, etc.).
- To participate in the cleaning of any specialized equipment for activities.

I will report any possible COVID-19 exposure or symptoms to the designated medical professional.
I voluntarily agree to assume all risks and accept sole responsibility for any injury and/or illness to myself. I hereby release, covenant not to sue, discharge, and hold harmless the Colts Youth Organization, their officers, officials, agents, volunteers, employees, other participants, sponsoring agencies, Drum Corps International ("Releasees"), with respect to any and all injury, illness, disability, loss or damage to person or property, expenses, and/or death arising out of or relating to COVID-19 or any other reason. I understand this release includes any claims based on the actions, omissions, or negligence of the Releasees, and whether a COVID-19 infection occurs before, during or after my participation. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

___/___/_____ _____ _____

Date Signed Name Printed Signature

ACCESS OF MEDICAL INFORMATION:
I hereby authorize the Colts Youth Organization to inspect or secure copies of medical records and/or any data relating to injury or illness. A photocopy of this authorization shall be deemed as effective and valid as the original.

_____ _____ _____ _____

Signature Date Witness Date

PARTICIPATION AND CARE:
I consent to volunteer with the Colts Youth Organization. I desire to receive proper medical treatment in the event of illness or accident. I consent to the administration and communication of any medical treatments in the best judgment of Colts personnel and accept financial responsibility for treatments.

_____ _____ _____ _____

Signature Date Witness Date

PERMISSION TO USE INSURANCE:
In case of emergency, I authorize the attending Colts staff member to sign release and consent forms for admitting and treatment:

_____ _____ _____ _____

Signature Date Witness Date

PERMISSION TO THE CLINIC, HOSPITAL, OR HEALTH CARE PROVIDER:
If emergency treatment or surgery is required, I authorize the attending Colts staff member to sign release, admittance, and consent forms for admitting, surgery, and/or related treatment:

_____ _____ _____ _____

Signature Date Witness Date