COLTS DRUM & BUGLE CORPS MEDICAL HISTORY FORM

Contracted members must also submit a copy of insurance card, physical, and immunization record.

Student Name_____ Sex_____ Section_____

Student Cell Phone_____ Birthdate_____

Address_____ City, State, Zip_____

Please answer **all** questions by circling "YES" or "NO". Explain "YES" answers in the area below.

1.	Have you had any medical problem or injury since your last physical?	YES	NO
2.	Have you ever been hospitalized?	YES	NO
3.	Have you ever had surgery?	YES	NO
4.	Do you use nicotine products? (vaping, cigarettes, chewing tobacco, etc.)	YES	NO
5.	Are you taking any other pills, vitamins, minerals, supplements, herbal treatments, or energy/enhancing drinks/powders/pills/shots/foods?	YES	NO
6.	Have you ever passed out during exercise?	YES	NO
7.	Have you ever had shortness of breath after exercise?	YES	NO
8.	Have you ever had chest pain during or after exercise?	YES	NO
9.	Have you ever been dizzy during a workout?	YES	NO
10.	Do you have high or low blood pressure?	YES	NO
11.	Do you have any skin problems (itching, rashes, acne)?	YES	NO
12.	Have you ever had a head injury, concussion, or been knocked out?	YES	NO
13.	Have you ever had a seizure?	YES	NO
14.	Have you ever had a stinger, burner, or pinched nerve?	YES	NO
15.	Have you ever had heat cramps or muscle cramps?	YES	NO
16.	Have you ever had or been diagnosed with a heat related illness?	YES	NO
17.	Have you ever had problems with your vision or eyes?	YES	NO
18.	Do you wear glasses, contacts, or protective eyewear?	YES	NO
19.	Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries of any body parts? (*Please Circle and add notes below)* Head Shoulder Arm Thigh Neck Elbow Knee Chest Forearm Shin/Calf Wrist Ankle Hip Hand Finger(s) Abdominal Back	YES	NO
20.	Have you ever had any other medical problems (mononucleosis, diabetes, seizures, asthma, etc.)? Please list:	YES	NO
21.	Are you currently under the care of a physician? IF YES Explain here:_____	YES	NO
22.	Have you been prescribed medications? If yes to prescription medications, are you taking them? *Please list prescription(s) here, whether taking or not:*_____ _____ _____	YES YES	NO NO
23.	Have you ever had any mental health concerns? (ADD, ADHD, anxiety, depression, suicidal thoughts, other mood disorders, etc.)	YES	NO
24.	If Female: Do you have menstrual periods? What was the longest time between periods in the past year, and are they regular? Time between_____ Regular?:	YES YES	NO NO
25.	Have you been tested for sickle cell anemia or sickle cell trait? If Yes, have you been diagnosed with sickle cell anemia or sickle cell trait?	YES YES	NO NO

26. Medicine allergies: Please list medications you are ALLERGIC TO here – please be specific:

_____

27. Other allergies: Please list any other allergies here:

_____

28. Please list other medications you USE here – please be specific:

_____

_____

YES answers - PLEASE EXPLAIN ANY "YES" ANSWERS (feel free to attach a sheet as necessary):

_____

_____

_____

MEAL PLAN/FOOD ALLERGIES – We offer two meal options (Standard and Vegetarian), and are sensitive to individual allergies. We do not offer a vegan meal option as we cannot sustain the nutritional demands of tour with this dietary choice.

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

Please LIST any FOOD ALLERGIES or sensitivities here (even if noted above, including dairy, soy, gluten, etc):

_____

COLTS DRUM & BUGLE CORPS INSURANCE FORM

PLEASE COMPLETE AND RETURN TO colts@colts.org; 2300 Twin Valley Drive, Dubuque, IA 52003; or Fax 844-347-5323

Student Name_____ Student Cell Phone_____

Sex Assigned at Birth_____ Gender Identity_____

Student Birthdate_____ Student Email_____

Were you ever diagnosed with COVID-19? YES NO COVID-19 Vaccine (please circle): Moderna Pfizer J&J Other

Primary Parent/Guardian_____

Address _____

City/State/Zip _____

Employer's Name _____

Employer's Address_____

Cell Phone_____

Email_____

Other Parent/Guardian_____

Address _____

City/State/Zip _____

Employer's Name_____

Employer's Address_____

Cell Phone_____

Email_____

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 _____ Insurance Phone _____

Authorization from insurance required before seeing specialist? (Y/N) _____

Does your insurance provide coverage during times of travel out of state? (Y/N) _____

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

Does your insurance cover (please note Y/N): Ophthalmology (Eye)_____ Dental_____ Pharmacy_____

Please list procedures to be taken if a specialist is needed:_____

Consents *(Parent signature required if student is 17 years of age or younger)***:**

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. I certify that the answers provided are true, complete, and correct to the best of my knowledge. **Please notify the Colts of any changes immediately.**

_____ _____ _____ _____

Signature Date Witness Date

PARTICIPATION AND CARE:

I consent that the above named student has permission to participate with the Colts Youth Organization, and has permission to engage in practices, tour, travel, and performances. I, the undersigned, desires said student to receive proper medical treatment in the event of illness or accident. I consent to the administration and communication of any medical treatments deemed necessary and accept financial responsibility for treatments. In accepting this consent, the Colts agree to notify me in a reasonable amount of time in the event of any serious accident or illness.

_____ _____ _____ _____

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, and I cannot be reached, I authorize the attending Colts staff member to sign proper release, admittance and consent forms for admitting, surgery, and/or related treatment:

_____ _____ _____ _____

Signature Date Witness Date

Colts Youth Organization – COVID-19 and General Waiver

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, and/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 | Member Signature | Member Name Printed

___/___/_____ _____

Date Signed | Parent/Guardian Signature (if member is under 18)

Colts COVID-19 Medical Form Supplement

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

Did you have symptoms with COVID-19 which were moderate or severe? (ex.: shortness of breath, exercise intolerance, chest tightness, dizziness, syncope, or palpitations) Circle One: Yes No

If yes, please explain_____

Did you need to be hospitalized due to COVID-19? Circle One: Yes No

COVID-19 Vaccine Type: Moderna___ Pfizer___ Johnson & Johnson___

Date(s) Received: _____ _____

COVID-19 Booster? Yes No If yes, Type: Moderna___ Pfizer___ J&J___

If yes, Date Received: _____