



LEGENDS MEDICAL AND RELEASE FORM

NAME _____ SS# _____
MAILING ADDRESS _____

City _____ State _____ Zip _____
Phone - Home _____ Phone - Mobile _____ DATE OF BIRTH _____
mm/dd/year

PHYSICIAN and INSURANCE DETAILS

Physician Name _____ Insurance Company Name _____
Clinic/Hospital Name _____ Policy Number _____
Clinic/Hospital Address _____ Insurance Company Address _____
Clinic/Hospital City, State, Zip _____ Insurance Company City, State, Zip _____
Clinic/Hospital Phone Number _____ Agent Name or Name of Company group policy _____
Agent or Company Phone Number _____
Other insurance info (please explain) _____

Member is insured under:

Father's Policy _____ Mother's Policy _____ Own Policy _____

PARENT AND EMERGENCY CONTACT INFORMATION

Father/Guardian Name _____ Emergency #1 Name _____
Phone - Home _____ Emergency #1 Phone - Home _____
Phone - Work _____ Emergency #1 Phone - Work _____
Phone - Mobile _____ Emergency #1 Phone - Mobile _____
Mother/Guardian Name _____ Emergency #2 Name _____
Phone - Home _____ Emergency #2 Phone - Home _____
Phone - Work _____ Emergency #2 Phone - Work _____
Phone - Mobile _____ Emergency #2 Phone - Mobile _____

MEDICINE ALLERGIES AND USE

Place an "x" in the proper column to indicate which medications you use or are allergic to.

Use	Allergy	Use	Allergy
_____	_____ aspirin	_____	_____ demerol
_____	_____ penicillin	_____	_____ antibiotics
_____	_____ sulfa	_____	_____ sedatives
_____	_____ codeine	_____	_____ other (_____)

MEDICATIONS

Are you currently taking any prescription medications on a regular basis? _____ Yes _____ No
If yes, answer the following:

Medication	Dosage	When taken	For
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last tetanus shot ____/____/____ Do you wear glasses/contacts _____ Do you smoke? Yes No

MEDICAL HISTORY

History of Treatments: Please describe medical attention given to the member during the past two years, and describe the illness, treatment or injury. (Please attach additional information if necessary for full disclosure)

<u>Date</u>	<u>Illness, symptom, injury</u>	<u>Treatment</u>
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Place an "x" next to any of these illnesses you have had or are prone to have:

- | | | | | | |
|--------------------------|----------------|--------------------------|---------------|--------------------------|--------------------|
| <input type="checkbox"/> | Eczema | <input type="checkbox"/> | Measles | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | Hives | <input type="checkbox"/> | Mononucleosis | <input type="checkbox"/> | Nervous exhaustion |
| <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | Tonsillitis |
| <input type="checkbox"/> | Diverticulitis | <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | Polio | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | Hernia | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | Asthma |

Place an "x" next to any of these illnesses you have had or are prone to have, either *sometimes or frequently*:

- | Nose and Throat | Mouth | Head and Neck | Cardiovascular |
|--|---|--|---|
| <input type="checkbox"/> congested nose | <input type="checkbox"/> dental problems | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> itching or burning | <input type="checkbox"/> neck and pains | <input type="checkbox"/> racing heart |
| <input type="checkbox"/> sneezing spells | <input type="checkbox"/> sore tongue | | <input type="checkbox"/> chest pains |
| <input type="checkbox"/> head colds | <input type="checkbox"/> taste changes | Respiratory | <input type="checkbox"/> dizzy spells |
| <input type="checkbox"/> nose bleeds | | <input type="checkbox"/> coughing spells | <input type="checkbox"/> shortness in breath |
| <input type="checkbox"/> sore throat | Skin | <input type="checkbox"/> coughs up blood | <input type="checkbox"/> swollen feet or ankles |
| <input type="checkbox"/> enlarged tonsils | <input type="checkbox"/> acne | <input type="checkbox"/> excessive swelling | <input type="checkbox"/> leg cramps |
| <input type="checkbox"/> hoarse throat | <input type="checkbox"/> itching and bleeding | <input type="checkbox"/> inadequate sweating | |
| <input type="checkbox"/> bee sting allergy | <input type="checkbox"/> bleeds easily | <input type="checkbox"/> sun "poisoning" | |
| | <input type="checkbox"/> bruises easily | <input type="checkbox"/> wheezes | |
| Musculoskeletal | <input type="checkbox"/> sunburns easily | | |
| <input type="checkbox"/> aching muscles | | | |
| <input type="checkbox"/> swollen joints | | | |

Any other serious illnesses or operations you have had:

CONSENT AND RELEASE

I acknowledge that _____ is a member of Legends and engages in rehearsals, tour, travel, and performances. I, the undersigned parent or guardian, desires that said member receives the proper medical treatment in the event of illness or accident. I, as said parent or guardian, consent to the administration of all medical treatments as is deemed necessary, and accept financial responsibility for said treatments. In accepting this consent, Legends agrees to notify me in reasonable amount of time in the event of any serious accident or illness.

Parent or Guardian	Date	Witness	Date
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To the hospital:

In case of emergency, I as parent or guardian, authorize the attending Legends staff member to sign release and consent forms for admitting and treatment of: _____.

Parent or Guardian	Date	Witness	Date
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To the hospital and surgeon:

If emergency surgery is required, and I cannot be reached, I authorize the attending Legends staff member to sign proper release, admittance, and consent forms for surgery and related treatment of: _____.

Parent or Guardian	Date	Witness	Date
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