

OREGON MARCHING AND ATHLETIC ARTS PROGRAM (OMAAP)

PERSONAL HEALTH AND MEDICAL HISTORY

To be filled out by parent, guardian, or adult participant. Please print in ink.

IDENTIFICATION

Name _____ Date of birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone _____

Home address _____ City _____ State _____ Zip _____

Business address _____ City _____ State _____ Zip _____

If person named above is not available in the event of an emergency, notify:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health/accident insurance carrier _____ Policy No. _____

Circle Yes or No to all items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants: Yes No Explain: _____

GENERAL INFORMATION:

ADHD (Attention-Deficit
Hyperactivity Disorder) Yes No

Convulsions/seizures Yes No

Hemophilia Yes No

Asthma Yes No

Diabetes Yes No

High blood pressure Yes No

Cancer/leukemia Yes No

Heart trouble Yes No

Kidney disease Yes No

Explain: _____

Please list ALL medications taken in 30 days prior to the first practice: _____

List any medications to be taken from the first practice through the end of the performance season, including drug, dosage, route (oral, injection, etc.), and frequency: _____

List any physical or behavioral conditions that may affect or limit full participation in any OMAAP practices or performances _____

List equipment needed such as braces, glasses, contact lenses, etc.: _____

Immunizations: (Give date of last inoculation.)

Tetanus toxoid _____

Measles _____

Polio _____

OR DPT _____

OR MMR _____

Hepatitis A _____

Varicella _____

Hepatitis B _____

OR Chicken pox _____

I give permission for _____'s full participation in OMAAP, subject to limitations noted herein.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____

MEDICAL EVALUATION

To be filled out by a licensed health-care practitioner*

Name _____ Age _____

NOTE TO LICENSED HEALTH-CARE PRACTITIONERS*: The person being evaluated will be participating in six weeks or more of an Oregon Marching and Athletic Program that may include strenuous activity (including marching, carrying heavy instruments, dancing, running, etc.) up to three hours at one time. Please review the health history with the participant. Explain any "abnormal" evaluations.

PHYSICAL EXAMINATION

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Circle: N = normal, Abn = Abnormal

Growth development N Abn

Teeth N Abn

Genitalia N Abn

Skin N Abn

Cardiopulmonary system N Abn

Musculoskeletal N Abn

HEENT N Abn

Hernia N Abn

Neurobehavioral N Abn

Explain: _____

Limitations:

Activity restrictions _____

Diet restrictions _____

Comment on any need for medical assistance devices: _____

Signature _____ Printed name _____ Date _____
Licensed health-care practitioner*

Address _____ Phone _____

City, State, Zip _____

*Examinations conducted by licensed health-care practitioners, other than physicians, will be recognized for OMAAP purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.