Worcester Chamber Music Society
Be engaged

ChamberFest 2023

ADULT RELEASE & MEDICAL FORM

(for those over 18 years of age)

Please read and indicate your response:

___Yes ___No *I do support* and agree to abide by all ChamberFest regulations and policies and to uphold the objectives of the Camp.

___Yes ___No Additionally, *to provide for the safety of all participants, faculty and staff,* and to provide an environment free from distraction, I will not bring any fireworks, matches or lighters, items of incendiary nature, explosives, gunpowder, firearms, ammunition, knives, or weapons of any kind (including toy weapons) to the Festival. In addition, I will not bring any illicit drugs, any other illegal substance, or inappropriate reading materials. Trinity Lutheran Church is not responsible for the loss of instruments or personal belongings.

___Yes ___No *I give permission* to be photographed, filmed, interviewed and have work samples published in print and/or on the internet for ChamberFest promotional purposes.

___Yes ___No *I agree to dissolve* the Worcester Chamber Music Society of any liability and responsibility if I choose to leave the Trinity Lutheran Church campus for any reason. I understand that I will not be covered by the WCMS insurance policy at these times.

Name of adult participant/faculty/staff member_____

Signature of adult participant/faculty/staff member_____

Date_____

Personal & Emergency Contact Information

Name_____ Home Phone_____

Home Address_____Cell Phone_____

Work Address _____ Work Phone_____

Emergency contact_____ Home Ph_____ Cell Ph _____

Allergies, Health History, Insurance

Name of participant_____ M F Birth Date_____Age_____

List all allergies _____

Operations or serious injuries including dates _____

Disability or chronic or recurring illnesses _____

List any specific activities to be encouraged or limited by physician's advice_____

List any dietary modifications _____

List any current medications _____

Name of family physician_____ Telephone Number _____

Name of family medical insurance / hospital insurance _____

Carrier _____ Policy #_____ Group #_____

Consent to Medical Treatment & Authorization to Release Information

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed Festival activities except as noted.

I, _____, do hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment,
Printed Name of Participant

and hospital service that may be rendered under the general or special instructions of

_____,
Printed Name of Participant's Physician Physician's Telephone Number

or any physician ChamberFest may call, whether such diagnosis or treatment is rendered at the office of said physician, at a licensed hospital, or on the college campus. It is understood in the case of a major accident or illness, reasonable effort will be made to reach the doctor listed above before any other physician is called by the ChamberFest staff. It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize ChamberFest or the physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing or until the end of ChamberFest. I hereby authorize any hospital or physician, or any other person who attended to or examined me to furnish WCMS's insurance company or its representative any and all information with respect to any illness, medical history or consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this shall be considered as effective and valid as the original.

Signature of adult participant/faculty/staff member

_____ **Date**_____

Witness_____ **Date**_____

A photocopy of this authorization shall be considered as effective and valid as the original.