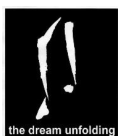


The Institute for the Musical Arts

PO Box 867 Goshen, MA 01032 Email: info@ima.org

This page to be completed by Student

Student Name:___________________________________ Age: _________ Date:______________

Is this your first IMA Camp Session: YES____ NO____ When did you attend:___________________________

A note to students: Answers to this questionnaire give us an idea of your musical interests, skill level and goals for the session. There are no right or wrong answers.The more we know about you in advance, the more we can be prepared to meet your needs. Please fill out this form yourself.

Primary Instrument:______________________ How long have you played it:______________________________

Secondary Instrument:_____________________ How long have you played it:______________________________

Do you **sing**? YES____ or NO____

If YES, tell us more about it:____

Do you know how to **read music**? YES___ or NO___

Have you had musical **lessons**? YES___ or NO___

If YES, for what:__________________ When/How Long:____

Do you **write** songs, musical compositions, journal writing or poetry? YES____ or NO____

If yes, please attach anything you would like to share with us.

Have you **performed** in any way such as a play, a show or with a band? YES____ or NO____

If yes, what & when____

Are there any other instruments that you are interested in learning to play? YES____ or NO____

If Yes, what instruments and why:

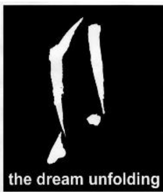
What musicians and or bands do you like and why?

What are your goals for this session?

Is there anything else about you or your musical background/skills/interests that you would like us to know?

Food Allergies or Restrictions? NO _____ YES _____ If yes, what:____

Foods you dislike:____________________________________ Like:____



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Student Name:____ Date:____________

The Post-Concert Potluck

The final concert take place at 3pm on the last Sunday of the session. There is a potluck immediately following. Please let us know how many people you expect to join you and what you will contribute to the meal.

We will be attending the potluck after the performance with _______ number of people in our party.

We will bring:

______ Salad
______ Bread
______ Drinks
______ Vegetarian Entrée
______ Non-Vegetarian Entrée
______ Dessert
______ Other side dish
______ Paper Cups
______ Paper Plates
______ Napkins

--

Pre-Teen/Teen Camp Release information

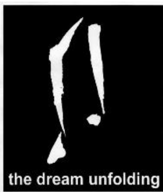
Student Name____

I understand that my child______________________________________ is to be picked up from IMA's Rock 'n Roll Camp at 165 Cape St. Goshen MA 01032 NO LATER than 6pm on the last day of the session and that IMA will release her to __________________________________ who is assigned to pick her up.

I further understand that any changes to the party who will pick up the student must be in writing, signed by the child's parent or legal guardian and received by the executive director (Ann Hackler) of IMA before the child will be released to any person not named on this form.

_______________________________________ _______________________________________ __________

Name of Parent or Legal Guardian Signature of Parent or Legal Guardian Date



The Institute for the Musical Arts

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Primary Health Information/Guardian Authorization Form

Information on this form is gathered to assist us in identifying appropriate care.

Student Name_______________________________________ Birthdate______________ Age________

Health History:

Check all that apply

	Frequent Ear Infections
	Convulsions
	Bleeding/Clotting Disorders
	Mononucleosis
	Measles
	Heart Defect/Disease
	Diabetes
	Hypertension
	Chicken Pox
	German Measles/Mumps

Operations or serious injury dates_______________________________
Chronic illnesses or medical condition_____________________________
Dietary restrictions____
Current medications____
Other diseases____

Name of Dentist/Orthodontist__________________ Phone____________
Name of Family Dr____________________________ Phone____________
Do you carry medical/hospital insurance _______Yes _______ No

Carrier____________________________________
Policy/Group #_______________________________

Allergies:

	Hay Fever
	Insect Stings:
	Asthma
	Ivy Poisoning, etc:
	Penicillin, other drugs:
	Food(s):
	Other:

Will your daughter have been fully vaccinated by the first day of her session?
___ Yes ___No If so, will she have also had a booster shot? ___Y ___N

Has the student menstruated ________ Yes _______ No
If no, has she been told about it ________ Yes _______ No
If yes, is her menstrual history normal ________ Yes ________ No
Has the student had head lice in the past year ________ Yes ________ No
If yes, when ______________ Is she lice free now ________ Yes _______ No

Is there any additional information about you(r) daughter's physical health, mental health or abilities that we should know in order to better serve her? ____
____

Permissions: *Must be completed for attendance, guardian authorization.*

The student described will engage in all session activities except those noted by me or our physician. I give permission to medical personnel selected by the session director to provide routing health care, to administer certain over-the-counter medications as needed and to provide any health related transportation. In the event that I cannot be reached in an emergency, I give permission to the IMA physician to secure and administer treatment, including hospitalization for the student named above. On arrival day, IMA personnel have the right to refuse to admit any student who does not meet acceptable health conditions (e.g. temperature, communicable diseases, etc.) I attest that she has had no serious illness or operations since her doctor's examination.

I also give permission for photographs and videos of my child taken while engaged at IMA to be used for promotional purposes including print and digital mediums, i.e. brochures, the IMA website and Facebook page.

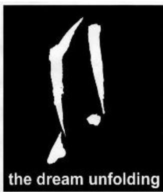
____ ________________

Signature of Adult Student or Parent/Legal Guardian Date

I also understand and agree to all the above permissions given by my parent or legal guardian.

____ ________________

Signature of minor student Date



The Institute for the Musical Arts

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Authorization to Administer Non-Prescription Medication

(to be completed by adult student/parent or legal guardian)

Student Name:____ Date of attendance:_______________

Please check off which non-prescription medications you give permission to be administered by the Health Care Manager to the above-named student on an as needed basis. All over the counter medications for students will be kept in the original containers containing the original labels, which includes directions for use.

____ Acetaminophen **(Tylenol)**: To relieve headaches, minor aches, fever, menstrual cramps. Contains no aspirin.
____ Ibuprofen **(Motrin/Advil)**: To relieve headaches, tooth aches, minor aches, fever, menstrual cramps. Contains no aspirin. *Caution: people with severe allergic reaction to aspirin must not take ibuprofen.
____ Diphenhydramine **(Benadryl)**: Contains antihistamine for temporary relief of sneezing, runny nose, itchy eyes and throat (due to allergies and colds). Also for pain and swelling due to insect bites.
____ Giuifesin/Dextromethorphan **(Robitussin DM)**: Loosens chest congestion/quiets cough
____ Liquid Antacid **(Mylanta/Maalox)**: Provides temporary relief of acid indigestion and/or nausea
____ **Sunscreen/Insect Repellant**: May be applied by counselor or other IMA staff
____ Topical ointments (**Bacitracin**, **Calamine**, **Hydrocortisone**; burn gel containing aloe/lidocaine): To protect against infection or relieve itching/pain from insect bites, rashes or superficial burns.

I understand that all medications, both prescribed and over the counter, are required to be in the original container. This requirement covers vitamins and homeopathic remedies that I may provide.

____ ____________________
Signature of Adult Student/Parent or Legal Guardian Date

FOR OFFICIAL USE ONLY:

Date	Medication Name & Dose Administered	Reason	Signature

Thanks for getting us all the important details!

After you're done filling in all the information be sure and save a copy of the completed form (via "save as" not "save") to your computer/laptop/typewriter/etc. Did she say typewriter? She did! At least I know that, after 6 pages of forms, you're still reading this! 😉 Where was I… oh yes, saving the document. Saving it that way, will prevent you from having to fill it out all over again. Ah, now you're really focused. I wouldn't want to have to fill this out more than once either.

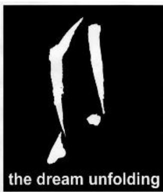
Be sure to get these forms back to us as soon as possible so that we can better prepare for the student's session.

Ways to do that:

Electronically: Pay for the session on our website then email this form to us at info@IMA.org
Manually: Print out the filled in document and send it to us at PO Box 867 Goshen MA 01032 with either a receipt for online payment or a check made out to IMA.

The following two pages are for the student's physician to complete. These need to be turned into us no later than the first day of the session.

We look forward to ***Rockin' the Summer*** with you!



The Institute for the Musical Arts

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TO BE COMPLETED BY DOCTOR

Student Name____ **DOB** _________________

Immunization History: Required immunization must meet Massachusetts standards. Please record the date (month and year) of the basic immunizations and most recent doses.

Vaccine	Year of Basic Immunization	Year of last booster
Diphtheria/Pertussis/Tetanus DPT or	1. 2. 3.	1. 2.
Tetanus/Diphtheria TD or		
Tetanus/ Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeolar		
Mumps		
Rubella (German measles, 3-Day measles)		
Tuberculin test given		
Haemophilus Influenza B (HIB) Hepatitis B		

Health Care Recommendations by a licensed physician:

I have examined the above student within the past 12 months. Date examined ______________________
Height _____________ Weight _____________ Blood Pressure _______________

The applicant is under the care of a physician for the following condition(s): ____
Current treatment (include medications):____
Explanation of any loss of consciousness, convulsions, or concussion:____
Does applicant have epilepsy? _______ Yes _______ No Does applicant have diabetes? ________ Yes ________ No

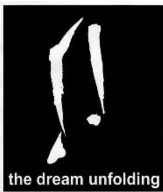
In my opinion, the above's condition _____ does ______ does not preclude her participation in an program activities.

Recommendations and restrictions while at IMA Rock n Roll Camp for Girls:

Any treatment to be continued at IMA_ ____
Any medically prescribed meal plan or dietary restrictions ____
Any allergies (food, drug, plants, insects, etc) ____
Activities to be encouraged or limited ____
Additional health information ____

Licensed Physicians Name _____________________________________ Clinic Name _______________________________________
Address ____ Phone ______________________________
Date of form completion (must be within 2 months of attending a session) ___________________________________

____ ______________________
Signature of examining physician Date



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Medication Information Form
TO BE COMPLETED BY DOCTOR

Note to Doctor: One form per medication. Each prescribed medication will need an individual authorization. Duplication of blank form is authorized.

Name of Student:____ Date of birth ____/____/____

Street Address:_________________________________ City__________________ St _____ Zip_________

Food/Drug Allergies____

Information on Prescribed Medication

Name of Medication____

Condition for which medication is being given____

Route of Administration____

Dose given at the session ____

Frequency____ Quantity Received________________________

Date Ordered________________________ Duration of Order ____________________

Expiration date of medication received____

Is this a controlled medication___________________________

Special storage requirements____

Specific directions (e.g. on empty stomach/with water)____

Specific precautions____

Possible side effects/Adverse reactions and Management_____________________________________

____

Physician or Dentist Name____

Street Address _________________________________ City__________________ St_______ Zip__________

Phone Number_________________________________

____ ___________________

Physician or Dentist Signature Date