The International Center for the Arts at Monte Castello, LLC

Medical Information Form

All information given below is requested in order to provide for your comfort and safety and to assist in case of an emergency. This information is confidential and private and will not be shared with any other parties, except emergency medical personnel.

Personal Information

Name

Gender

Birth date (Month/Date/Year)

Address in my home country

Program title

Session Dates:

Emergency Contact Information

Person to contact in an emergency

Telephone - Cel

Telephone - Home

Telephone - Work

Address:

Relationship to applicant

INTERNATIONAL CENTRE FOR THE ARTS - MONTE CASTELLO DI VIBIO -

Authorization to Release Health Records and Permission for Emergency Medical Treatment

Please complete and sign the following.

As a participant in an International Center for the Arts at Monte Castello, LLC program, I,

authorize the release by The International Center for the Arts at Monte Castello, LLC, of the medical information pertaining to me contained in the below to health care professionals in the event of an emergency.

Signature of applicant

Date - month/day/year

Printed name

Program title

Participation in an International Center for the Arts program is contingent upon review of the applicant's completed health forms. The International Center for the Arts at Monte Castello, LLC normally requires that all students participating in our programs show medical and psychological stability, as determined by The International Center for the Arts at Monte Castello, LLC. for no less than six months prior to the group's departure date.

Personal Health History

Review of Illnesses and Symptoms

Please complete the following, adding additional paper if necessary.
DO NOT LEAVE ANY QUESTION BLANK.

Have you consulted or been treated by clinics, physicians, or other practitioners within the past two years (other than routine check-ups)?
If yes, give details.

yes no

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Have you ever been hospitalized or had a serious acute illness?
If yes, give diagnosis and date.

yes no

Do you have any chronic/recurrent illness?
Any permanent/chronic injury or physical disability?
If yes, give details.

yes no

Have you had any allergic reaction to past immunizations, prescription, or over-the-counter medicines?

yes no

Do you have a history of asthma or other respiratory ailment?
If yes, give details.

yes no

Are you currently taking any medications including prescription, over-the-counter, and herbal remedies for any medical, psychological, or other conditions?
If yes, list and give details.

yes no

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Do you have any health requirements or dietary restrictions?

If yes, explain. yes no

In the last two years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, for any mental, emotional or psychological conditions including eating disorders and substance abuse? If yes, give details.

yes no

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Please check if you have had:

- Allergy (please specify):
  - Hay fever
  - Bees/wasps
  - Pet/animal dander
  - Foods
  - Other
- Eye or Vision issues
- Hearing loss
- Anemia
- Bleeding/Clotting
- Bladder/kidney problems
- Cancer or Leukemia
- Immune System problems
- Heart problems
- Diabetes
- Back problems
- Painful swollen joints
- Abdominal pain

- Chronic indigestion, diarrhea
- Stomach ulcer
- Impaired use of any limbs
- Epilepsy (seizures)
- Recurrent dizziness/faintness
- Severe headaches/migraines

Please explain if you have been, or are being, treated for any of the above. Include information on regular treatment medications.