

**VALLEY OF THE MOON**  
**SCOTTISH FIDDLE SCHOOL 2008**  
**Minor Release Form**

I am the parent or legal guardian of \_\_\_\_\_, and I hereby grant permission for my minor child to participate in the Valley of the Moon Scottish Fiddle School.

I do assume any and all risks that might be associated with the activities that my child may be involved in at the Valley of the Moon Scottish Fiddle School. I release Scottish Fiddlers of California and all camp directors and staff from any and all liability due to any accident or injury which may result during my child's participation in this camp.

I understand that if my child does not follow acceptable behavior, as established by the camp staff and directors, I will be required to pay all expenses for returning my child home.

My child will attend the Valley of the Moon Scottish Fiddle School under the guardianship of: \_\_\_\_\_. I hereby grant permission for first aid to be administered to my child in the event that it becomes necessary. I also grant the guardian authority to act in my place and with the same authority as myself during the course of the camp, including the right to approve or decline emergency or other medical care in the event that I cannot be reached by camp staff. I request that in my absence, my child be admitted to any hospital or medical facility for diagnosis and treatment if deemed necessary by the guardian. I authorize physicians and nurses to perform any diagnostic procedures, treatment procedures and operative procedures to my child. Any medical care treatment that is to be provided beyond emergency first aid shall be done solely on the advice and direction of a licensed physician or other licensed medical care practitioner. I assume financial responsibility for all medical treatment that is provided. Known allergies, medical problems, or medications currently taken by my child are as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(signature of parent)

\_\_\_\_\_  
(date)

Phone \_\_\_\_\_

Alternate contact person and number in case of emergency:

\_\_\_\_\_

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Name and policy number for child's medical insurance provider:

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I agree to follow the instructions and directions given to me by the camp staff and my guardian.

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(signature of participant) (date)

**Form must be returned by July 1, 2008 to:**

Cherry Clark  
1281 Fifth Ave  
San Francisco, CA 94122

Any questions, call (415) 566-4355; email [vom@sonic.net](mailto:vom@sonic.net)

# VALLEY OF THE MOON FIDDLE SCHOOL HEALTH HISTORY AND MEDICAL RECORD

- To be filled out by parent -

Participant Name	Age
Address	City/St <span style="float: right;">Zip</span>
Home phone	Sex M F <span style="float: right;">Birthdate</span>
Parent/Guardian	Business phone
Parent/Guardian	Business phone
Emergency contact	Phone
Health insurance	Plan # <span style="float: right;">ID#</span>
MD	Phone
DDS	Phone

## HEALTH HISTORY

Please check any of the conditions that apply to your child:

ASTHMA	POISON OAK	CONTACT LENSES	EPILEPSY	HEARING AID
DIABETES	MEDICINES	INSECT BITES	BLEEDING	OTHER

Briefly explain the answers as indicated above:

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1. Recent surgery or serious injury (explain) \_\_\_\_\_

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  2. Recent exposure to any contagious diseases (explain) \_\_\_\_\_

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  3. Currently taking medication (explain) \_\_\_\_\_  
Send dosage, instructions & label correctly
  4. Any behavioral conditions (explain) \_\_\_\_\_
  5. Is child's immunization records up to date? \_\_\_\_\_yes\_\_\_\_no
  6. Date of last tetanus shot: \_\_\_\_\_

## AUTHORIZATION TO PARTICIPATE

The above general information and health history is correct to the best of my knowledge.

PARENT/GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, the undersigned, hereby grant permission to the medical personnel selected by the VOM staff to order the necessary treatment for my child in the event of an emergency and I cannot be reached. I also grant permission to the physician selected by the VOM staff to secure proper treatment for injection and/or anesthesia, and/or surgery for my child as named above. In addition, I authorize the medical facility which has provided the treatment to the above named child, to surrender custody of said minor to the VOM staff upon completion of treatment. This form may be photocopied for off site use.

PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

COMMENTS: