Indiana University Jacobs School of Music  
Summer Music Clinic Return Checklist

Deadline for return of materials: **June 2, 2017** by email, post, or fax. Students MAY NOT participate in the Clinic without completed forms. We encourage you to complete your registration as soon as possible.

Mail all forms to:

<table>
<thead>
<tr>
<th>IU Summer Music Clinic</th>
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<tbody>
<tr>
<td>I.U. Jacobs School of Music</td>
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<tr>
<td>1201 East Third Street, Merrill Hall 006</td>
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<tr>
<td>Bloomington, IN 47405</td>
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<tr>
<td>Fax forms to: 812-856-4207</td>
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<tr>
<td>Email forms to: <a href="mailto:iusmc@indiana.edu">iusmc@indiana.edu</a></td>
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</tbody>
</table>

The following materials are attached; please check off each item.

1. ____ This completed checklist
2. ____ Consent for Medical Treatment of a Minor with **copy of insurance card** (front and back), completed and signed.
3. ____ Medical Wellness Form, completed and signed by parent or legal guardian.
4. ____ Program Release, completed and signed by parent or legal guardian.
5. ____ Policies and Code of Conduct Participant Agreement, completed and signed.
6. ____ Photo Release Form, completed and signed.

Name of Participant: ____________________________________________

(Please print)

Signature of Parent or Guardian: ________________________________

PLEASE RETURN THIS FORM
**Consent for Medical Treatment (minors only)**

I, ________________________________, am the parent or legal guardian of ____________________________________________________________ and I authorize (name of program) ____________________________________________________________ to obtain emergency medical treatment of this minor by an appropriate health care professional should the need arise while he/she is attending the program.

Signature ___________________________ Date ___________________________

**Medical Information (all participants)**

Participant’s name __________________________________________

Age ___________ Birthdate ___________________________ Date of last Tetanus Toxoid __________________________

Past health/injuries __________________________________________ Present health __________________________________________

__________________________________________ Allergic reactions __________________________________________

__________________________________________ Present medication __________________________________________

☐ Check here if the participant has special needs and might require accommodations to fully participate in the program. A staff member will contact the parent or guardian for details.

Other information that would be useful in the event medical treatment is necessary:

**Insurance Information (all participants)** - Please attach a copy of the insurance card (front and back) with the form

Parents or legal guardians are responsible for the cost of a minor’s medical treatment. When available, insurance information will be processed by the health facility performing the treatment, otherwise you will be contacted for payment by cash, check or credit card.

Insurance company ___________________________ Address ___________________________

City/State/Zip __________________________________________

Policyholder’s name ___________________________

Policy number ___________________________

**Contact People (all participants)**

In an emergency, parents or legal guardians can be reached as follows:

Name __________________________________________ Relationship to minor __________________________________________

Address __________________________________________ Daytime phone ___________________________

City/State/Zip __________________________________________ Evening phone ___________________________

Cell phone __________________________________________

Name __________________________________________ Relationship to minor __________________________________________

Address __________________________________________ Daytime phone ___________________________

City/State/Zip __________________________________________ Evening phone ___________________________

Cell phone __________________________________________

If other information would be helpful in contacting you, please indicate: __________________________________________
Indiana University Jacobs School of Music
IU Summer Music Clinic
MEDICAL WELLNESS FORM 2017
.must be completed by a parent/guardian.

The Jacobs School of Music takes many precautions in an effort to ensure the safety of the young musicians entrusted to its care. At the IU Summer Music Clinic vigilance in all areas is a top priority. That is why we require you to complete this form containing supplemental contact, medical and music wellness information in addition to the standard “Consent for Medical Treatment” form required of all pre-college students attending an I.U. residential program. Please answer all points below as fully and specifically as possible. This form is due by June 2, 2017.

The data you supply about your child’s medications and medical conditions, allergies, dietary preferences will be held in strict confidence. Only the directors, administrators, and the adult counselors—the team most likely to be called on to respond to an injury or illness—will be privy to the information. It will help us to make your child’s stay at Indiana University healthier and happier even if this form is never needed for a medical emergency. In the unlikely event that a serious or potentially serious problem arises, Clinic personnel will make every effort to reach you as soon as the situation permits. To maximize your chances of being consulted if a problem arises, be sure to list all means by which we can contact you.

PRINT OR TYPE IN BLACK INK

---------------------------------------------------------------
Student: ________________________________________________________________________________________      Birthdate: __________________________
last name                                    first                                                 middle initial

Home telephone: ___________________________  Cell phone __________________________

Student E-mail (print!) ___________________________  Parent E-mail (print!) ___________________________

Home address: ____________________________________________________________________________

City: ___________________________  State: _________  Zip: ______________

Emergency Contact information:

Name: ___________________________  Day phone: __________________________  Evening: __________________________

Does the student have any DIETARY RESTRICTIONS? ___________________________

---------------------------------------------------------------

Parent/Guardian’s Signature ___________________________  Date ______________

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MISCELLANEOUS HEALTH INFORMATION (optional)

If your child has a condition that bears watching, the information you provide will help us to be on the alert for signs of a developing problem before the situation is serious.

Blood type, if known: ________________________

Student’s family or personal doctor __________________________________________ Phone ________________________________________

Medical Specialist treating the student: __________________________ Phone ________________________________________

Dentist or Orthodontist: __________________________________________ Phone ________________________________________

HAS THE STUDENT RECEIVED TREATMENT FOR ANY OF THE FOLLOWING in the last 4 years?

☐ Stress-related conditions (e.g., acid stomach, insomnia)
☐ Performance anxiety ☐ General anxiety, distraction, depression (specify)
☐ Frequent or severe headaches ☐ epilepsy or seizures
☐ Heart condition or other serious health problem (please specify) __________________________
☐ Diabetes ___________________________________
☐ Eating disorder (anorexia, bulimia, other) Currently under treatment? __________________________
☐ Learning challenge, e.g., dyslexia, ADD (Attention Deficit Disorder), ADHD, or other learning problem

Specify type, if professionally diagnosed: __________________________________________

☐ Anger management problem, conduct disorder or other behavior problem (specify) __________________________

Is the student currently receiving study counseling, family counseling or mental health counseling? yes no
If yes, is there anything the counselors should know about the student’s condition? Any warning signs they should be alerted to?

__________________________________________________________________________________________

__________________________________________________________________________________________

MEDICAL ALERT INFORMATION

List all regular medications (including eye drops), prescribed emergency medications, drug allergies, all other allergies, ongoing medical or psychological conditions, physical impairments, surgical history, and history of bone fractures. (Explain if necessary on a separate sheet of paper.)

Medications the student is currently taking: any side effects?

Has the student been advised to wear any of the following while practicing?

☐ brace (specify) __________________________ ☐ pad or splint (specify) __________________________
☐ Other protective device (specify) __________________________

Any other information that would be useful in the event medical treatment is necessary:

__________________________________________________________________________________________

__________________________________________________________________________________________

Medications the student is currently taking: any side effects?

__________________________________________________________________________________________

__________________________________________________________________________________________
I, the undersigned, give permission for my Child to participate in the IU Summer Music Clinic, offered on behalf of The Board of Trustees of Indiana University (“IU”), at the Forest Dormitory and Jacobs School of Music from June 18 - June 24, 2017 (the “Program”).

In consideration for my Child’s participation, I, on behalf of my Child, agree to the following:

1. I understand the Program consists of the following activities: Daily practice of a musical instrument and other movement associated with music activities, musical concert attendance, consumption of food and beverage, optional swimming, optional recreation activities (volleyball, Frisbee, soccer, bowling, etc.), staying overnight in a dormitory, and otherwise being present on Indiana University’s campus for the duration of the Program.

2. I understand that as part of my Child’s participation in the Program there are dangers, hazards, and inherent risks to which my Child may be exposed, including but not limited to, the risk of serious physical injury, temporary or permanent disability, and even death, as well as economic and property loss. I further understand that participating in the Program may involve other risks and dangers, whether known or unknown or reasonably foreseeable, including the following: drowning, food/drink allergies, sprains, cuts, bruises, fire or other emergency in the dormitory and/or on Indiana University’s campus.

3. I fully understand the scope of the activities and the risks involved. I voluntarily accept and assume all risks of injury, loss of life, or damage to property arising out of my Child’s participation in the Program.

4. I hereby release and fully discharge IU, including its officers, employees, and agents, from any and all claims or causes of action, including all liability for damage to personal property or personal injury which may result from my Child’s participation in the Program, that may be brought by me or my Child or for any injury or loss that my Child may suffer while participating in the Event, whether caused by negligence or otherwise, to the fullest extent permitted by law.

5. I further release, indemnify, and hold harmless IU, including its officers, employees, and agents, from and against any and all liability, actions, debts, claims, and demands of every kind whatsoever, including, but not limited to, any claim for negligence and/or any present or future claim, loss, or liability for which my Child may be liable to any other person or to IU that arises out of my Child’s participation in the Program.

6. In the event of an accident or serious illness, I hereby authorize representatives of IU to obtain medical treatment and transport for my Child on my behalf. I waive my right to receive informed consent prior to such transportation or treatment. I hereby hold harmless and agree to indemnify IU from any claims, causes of action, damages and/or liabilities, arising out of or resulting from the medical treatment or transport. I further agree to accept full responsibility for any and all expenses, including medical expenses that may derive from any injuries to my Child that may occur during his/her participation in the Program.

7. This Agreement shall be governed by and construed under the laws of Indiana. Notwithstanding any other agreement that I have signed related to this Program that purports to establish the venue for any litigation arising from this Program, I agree that I will file no action against The Trustees of Indiana University or its officers, employees, and agents, whether based on this Agreement or in any way otherwise connected to this Program, in any court other than the Circuit Court of Monroe County, Indiana.

8. I understand and agree to all of the terms of this Agreement. I understand that I am giving up substantial rights (including my right to sue) and acknowledge that I am willingly signing this document. My signature on this document is intended to bind not only myself and my Child, but also the successors, heirs, representatives, administrators, and assigns of myself and my Child.

______________________________  ______________________________
Child’s name                          Parent/guardian name

______________________________                       _________________
Parent/guardian signature                  Date
IU SUMMER MUSIC CLINIC
Policies and Code of Conduct Participant Agreement

1. To hold your spot in the IU Summer Music Clinic, a non-refundable $75 registration fee is due. Students that do not have a $75 fee paid will run the risk of forfeiting their spot. All fees are due by June 2 and are non-refundable past this date.

2. Dress in an appropriate manner at all rehearsals and concerts.

3. Smoking and the possession and/or consumption of alcohol and illicit drugs are prohibited and will result in immediate dismissal from the Clinic.

4. Students are required to be on their dorm floors by 10:30 pm. Room lights are to be off at 11:00 pm.

5. Students are required to attend all sessions and recitals. Absences must be cleared with the Head Counselor.

6. Students are required to wear lanyards and nametags at all times. Faculty and staff will stop anyone not wearing a nametag. Repeated violation of this will result in swift action from the head counselors (or camp director if appropriate/necessary).

7. Absolutely no bullying shall be tolerated. This includes verbal or physical bullying through inappropriate comments, language, or otherwise. This also includes cyber bullying (e.g. social media, email, cell phones.). Violation of this policy will result in immediate dismissal from the Clinic.

8. Participants shall maintain a positive attitude, take corrections politely, and apply them as needed.

9. Rooms do not have phones, although students may use their own. All cell phone activity must end prior to 11:00 pm, and cell phones must be turned off for concerts and recitals. Absolutely NO TEXTING during rehearsals, electives, or performances.

10. Any student who drove to Clinic will be required to leave the vehicle parked and locked for the week in a designated parking lot. All student car keys must be turned in to the Head Counselor’s office on Sunday (the Forest Center Desk will not issue a parking permit to a student unless a counselor confirms that the keys have been turned in).

11. Students are not allowed to travel in personal cars driven by someone else during the Clinic unless they have 1) A signed authorization form allowing them to meet with someone outside the Clinic 2) A signed Transportation Liability Form 3) Officially checked out with the Head Counselors.

12. Students will remain between the areas south of the IU Jacobs School of Music to and including Third Street, west to the IU Memorial Union, north to 10th Street and east to Union Street. Students should travel in groups. Travel beyond these areas requires signed parent authorization.

13. Students are required to have signed authorization forms to meet someone from outside the camp and they must sign out and in with the Head Counselors.

14. Lost keys will be replaced for $50 and lost meal cards will be replaced for $20.

15. In the dorm, no boys on girls’ floors and no girls on boys’ floors. Violation of this will result in swift action from the head counselors (or camp director if appropriate/necessary).

I have read this entire Agreement, I fully understand it, and I agree to be bound by it. I represent and certify that my true age is at least 18 years old or, if I am under 18 years old on this date, my parent or legal guardian has also signed the Agreement.

Participant Name (Print): ____________________________________________

Participant Signature: ____________________________________________ Date __________

If Participant is under 18 years old, his/her parent or guardian must sign below.

Parent/Guardian Name (Print): __________________________________________

Parent/Guardian Signature: __________________________________________ Date __________

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I (“Participant”) authorize The Trustees of Indiana University (“IU”), acting through its agents, employees, or representatives, to take photographs, video recordings, and/or audio recordings of me, including my name, my image, my likeness, my performance, and/or my voice (“Recordings”). I also grant IU an unlimited right to reproduce, use, exhibit, display, perform, broadcast, create derivative works from, and distribute, and sell the Recordings in any manner or media now existing or hereafter developed, in perpetuity, throughout the world. I agree that the Recordings may be used by IU, including its assigns and transferees, for any purpose, including but not limited to, marketing, advertising, publicity, or other promotional purposes. I agree that IU will have final editorial authority over the use of the Recordings, and I waive any right to inspect or approve of any future use of the Recordings. I acknowledge that I am not expecting to receive compensation for participating in the Recordings or for any future use of the Recordings.

I release and fully discharge IU, and its employees, agents, and representatives, from any claim, damages, or liability arising from or related to my participation in the Recordings or IU’s future use of the Recordings.

I have read this entire Consent and Release Form, I fully understand it, and I agree to be bound by it. I represent and certify that my true age is at least 18 years old, or, if I am under 18 years old on this date, my parent or legal guardian has also signed below.

Name of program: Indiana University Summer Music Clinic

Location of Recordings: Indiana University Date(s) of Recordings: June 18-24, 2017

Participant’s Signature ___________________________ Date _____ / _____ / _____

Participant’s Printed Name ___________________________

Address __________________________________________

City __________________________ State __________ Zip __________

Phone __________________________ Email __________________________

If Participant is under 18 years old, then his/her parent or guardian must sign below.

Parent/Guardian’s Signature ___________________________

Parent/Guardian’s Printed Name ___________________________