PITTSBURGH YOUTH SYMPHONY ORCHESTRA
The Baltics and Scandinavia June 2020

Dear Tour Participants:

The purpose of these forms is to provide accurate medical information about each participant who will be traveling with the Pittsburgh Youth Symphony Orchestra to the Baltics and Scandinavia from June 14 to June 25, 2020.

The information on these forms will help us provide the best care possible and secure treatment in the event of an emergency. **All information contained in these forms will be kept confidential** and only shared with medical professionals if the need of an illness or emergency arises.

If you would like to discuss any of the information on these prior to the tour, please contact the PYSO office and we can advise you on who will be the best person to contact.

Please complete the following forms and return the entire package by mail to PYSO, 600 Penn Avenue, Pittsburgh, PA 15222 **no later than March 1, 2020**.

- **PARTICIPANT HEALTH INFORMATION** (All students, chaperones and companions must complete)
  To be completed by parent or guardian if student is under 18 years of age or included in parent’s insurance.
    - PROVIDE COPY OF INSURANCE CARD WITH THIS FORM (Both sides)

- **PHYSICAL EXAM FORM** (orchestra members only)
  To be completed by participant’s physician. If a current (since June 2019) physical examination form is available, please supply a copy and have your physician verify with a current date on the form.

- **MEDICATION AUTHORIZATION FORM** (required for students – optional for chaperones and companions)
  To be completed by parent/legal guardian. The medication portion of the form must be signed by participant’s Physician.

Since each individual’s health is different, we recommend that you consult with your physician in order to determine which vaccines are recommended for travel to Finland, Estonia, Latvia and Sweden.

Return no later than March 1, 2020 by mailing to:

PYSO – 600 Penn Avenue – Pittsburgh, PA 15222
PARTICIPANT’S HEALTH INFORMATION FORM
(All students, chaperones & companions must complete)

PLEASE PROVIDE A COPY OF THE INSURANCE CARD (BOTH SIDES) WITH THIS FORM.

Participant’s Name _____________________________________________________________

Physician’s Name _____________________________________ Phone_____________________

PARTICIPANT’S HEALTH INSURANCE INFORMATION

Insurance Carrier or plan name _______________________________________________________

Group Number ____________________ Policy Number ______________________

Name of policy holder ___________________________________________________________

Name of employer (If group insurance _____________________________________________

Social security number of policy holder ______________________________________________

Does this policy cover the participant in Finland, Estonia, Latvia and Sweden?
YES _____ NO _____

Exceptions/Comments: _____________________________________________________________

*Please check with your insurance provider if the participant will be covered in Finland, Estonia, Latvia and Sweden while on tour.

EMERGENCY INFORMATION

Primary emergency contact: _________________________________________________________

Relationship ___________ Day Phone __________________________ Evening Phone _______

Cell phone ____________________________

Secondary emergency contact:

Relationship ___________ Day Phone __________________________ Evening Phone _______

Cell phone ____________________________

Only for PARENT/GUARDIAN of Orchestra Members:

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

In the event of an emergency, I hereby give permission to the medical personnel selected by PYSO to secure and administer medical treatment, including hospitalization, to order x-rays, routine tests, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the participant.

PARENT/GUARDIAN SIGNATURE ___________________________ Date _________________

Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the tour staff should be aware.

______________________________________________________________________________

______________________________________________________________________________

Return no later than March 1, 2020 by mailing to:
PYSO – 600 Penn Avenue – Pittsburgh, PA 15222
To be completed by Physician

Required Information from Orchestra Members Only

PHYSICALLY FIT TO TRAVEL
I have examined this individual and have found him/her physically fit to participate in the Pittsburgh Youth Symphony’s International tour to the Baltics (Estonia and Latvia) and Scandinavia (Finland and Sweden) from June 14-25, 2020.

I understand that the tour will follow a strenuous schedule that includes walking and sitting for long periods of time.

Comments: ________________________________________________________________

PHYSICIAN’S SIGNATURE ___________________________ DATE ________________
(Physician’s stamp)

Please also complete and sign the prescription medication section in the participant’s medication form.

PRESCTIPTION MEDICATIONS — To be signed by Physician

Required Information from Orchestra Members – Optional for All Others

_____ The participant does not take any prescription medications.

Medication: ___________________________ Dose ___________________________
Time or circumstance of administration _______________________________________
Duration of administration: _______________________________________________
Reason for administration _________________________________________________
Medication side effects to be aware of _______________________________________
Additional instructions ___________________________________________________

Medication: ___________________________ Dose ___________________________
Time or circumstance of administration _______________________________________
Duration of administration: _______________________________________________
Reason for administration _________________________________________________
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Additional instructions ___________________________________________________

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OVER-THE-COUNTER MEDICATIONS

Over-the-counter pain relievers/medication that may be administered to participant (as needed)

___ Pain Reliever (i.e. Acetaminophen/Aspirin/Ibuprofen)

___ Antacids/Digestive Aids

___ Anti-histamine/Decongestant

Other Over-the-Counter Meds__________________________________________________________

I hereby acknowledge and grant permission to PYSO or medical personnel to administer the above marked medication (s) to the participant during the Baltics/Scandinavia Tour June 2020.

PARENT/GUARDIAN SIGNATURE ________________________________  Date ________________

NOTE: ALL MEDICATION MUST BE IN ORIGINAL CONTAINERS FROM PHARMACY WITH PARTICIPANT’S NAME ON IT AND MUST BE ACCOMPANIED BY THE ORIGINAL PRESCRIPTION VALID FOR THE DURATION OF THE TOUR.

Participants must bring enough medication for the entire duration of the tour.