

### TO BE COMPLETED BY STUDENT

- For AMDA NY: Return by mail only; Attention: AMDA NY Admissions
- For AMDA LA: Return by mail only; Attention: AMDA LA Health and Wellness Center

Name (Legal): \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First Middle*

Permanent Mailing Address: \_\_\_\_\_  
*Street Apt # City State Zip Country*

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
*Month Day Year*

Are you an international student:  Yes  No

Name of your personal physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

I hereby authorize AMDA to notify the following people in case of emergency:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Are you covered by any medical and/or health insurance? If so, please provide company name and policy information.

Insurance Company Name \_\_\_\_\_ Customer Service Phone Number \_\_\_\_\_

Member ID \_\_\_\_\_ PPO or HMO \_\_\_\_\_ Group Number \_\_\_\_\_

I acknowledge that I have fully disclosed all information regarding my physical and mental health to my physician. I understand that AMDA's training is rigorous, requiring physical stamina and mental stability. I agree to inform AMDA immediately upon any change in my physical and/or mental condition.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

If applicant is under the age of 18, his/her legal guardian must complete the following:  
I hereby authorize the provision of treatment for my child for medical or psychological emergencies.

Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_



### PERSONAL MEDICAL HISTORY (1-8 to be completed by student)

1. Have you ever been treated for the following conditions:

	Y	N		Y	N		Y	N	Type of Reaction
ADD/ADHD			Eye Problems, Glasses or Contacts			<b>Allergy:</b>			
Anemia			Head Injury (Concussion)			Codeine			
Anxiety/Panic Disorder			Heart Disorder			Sulfa			
Arthritis			Hepatitis			Penicillin			
Asthma			High Blood Pressure			Insect Bites/Stings			
Bleeding Disorder			Kidney/Bladder/Urine Infections			Latex			
Cancer			Migraine Headaches			Other:			
Depression			Menstrual Disorders						
Diabetes			Mononucleosis			<b>Surgery:</b>			
Dizziness/Fainting			Orthopedic/Back/Bone Problems			Appendectomy			
Ear, Nose, or Throat Disorder			Recent Weight Loss			Tonsillectomy			
Eating Disorder			Skin Problems			Other:			
Epilepsy/Seizures			Physical Limitations						

2. Current Medications (including birth control and over-the-counter medications):

3. Mental Health History (depression, anxiety, etc):

4. Family Health History (high blood pressure, diabetes, etc):

5. Physical Exertion Questions:

Do you have chest pain when you perform physical activity? Yes No

Do you get faint or dizzy when you perform physical activity? Yes No

Have you ever had heat exhaustion, stroke, or other heat-related problems? Yes No

6. Have you ever had any muscle or tendon problems, broken bones (fractures) or serious joint injury?

- Head   Neck   Back   Shoulder   Upper Arm   Elbow   Forearm   Wrist  
Hand   Hip   Thigh   Knee   Lower Leg   Ankle   Foot

Explain all "YES" answers:

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### 7. REQUIRED VACCINATION

MMR: First Dose Given On \_\_\_/\_\_\_/\_\_\_ Second Dose Given on \_\_\_/\_\_\_/\_\_\_

### 8. RECOMMENDED BUT NOT REQUIRED:

Tetanus: Given On \_\_\_/\_\_\_/\_\_\_  Meningococcal: Given On \_\_\_/\_\_\_/\_\_\_  
 Varicella: First Dose Given On \_\_\_/\_\_\_/\_\_\_ Second Dose Given On \_\_\_/\_\_\_/\_\_\_  
 Hepatitis B: First Dose Given On \_\_\_/\_\_\_/\_\_\_ Second Dose Given On \_\_\_/\_\_\_/\_\_\_  
Third Dose Given On \_\_\_/\_\_\_/\_\_\_

### \* Immunization Exemptions:

Students may be granted exemption from the immunization requirements if they provide one of the following:

1. A signed statement from a physician documenting the student's vaccine contraindications.
2. A signed statement from a physician documenting other evidence of immunity.
3. A personal and/or religious belief exemption statement signed by the student (and parent or guardian if under 18 years of age upon entering AMDA).

### QUESTIONS 9-11 TO BE COMPLETED BY THE STUDENT'S PHYSICIAN (licensed medical doctor only)

Study at AMDA consists of intense training in acting, singing, and dancing. The program demands from the student both physical and emotional stamina. Your assistance in answering the following questions is appreciated.

9. Does the student have any condition which might limit participation in dance or movement classes?

Yes  No If yes, please specify: \_\_\_\_\_

Degree of limitation: \_\_\_\_\_

10. Does the student have any previous injuries of which AMDA should be aware?

Yes  No If yes, please specify: \_\_\_\_\_

11. AMDA's intense conservatory program demands from the student both physical and emotional stamina. Are there any factors relating to the student's ability to function successfully in this environment of which AMDA should be aware?

Yes  No If yes, please specify: \_\_\_\_\_

I examined \_\_\_\_\_ on \_\_\_\_\_  
Applicant's Name Date

and found his/her general condition to be \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Affix office stamp or print provider name and address to the right:

License # \_\_\_\_\_ State of License \_\_\_\_\_

