Model Medical Questionnaire

Drafted by: IUA Contingency Working Party

March 2011

IMPORTANT NOTICE:

It is not compulsory for this medical questionnaire to be used as drafted nor is it intended to replace the exercise of independent judgement. It is down to the individual company to judge their own circumstances when deciding whether or not to use this medical questionnaire. Advice should be sought from legal advisers for clarification of the use and intention of this suggested questionnaire, as IUA does not accept any responsibility of subsequent interpretation of the questionnaire.

NAME OF EXAMINEE:

PERIOD OF EVENT / TOUR:

(If possible please provide the Doctor / Physician with a copy of the tour / event itinerary)
DATE OF MEDICAL ASSESSMENT:

LOCATION OF MEDICAL ASSESSMENT:

EXAMINEE'S ROLE IN EVENT / TOUR (e.g. Singer / Guitarist / Drummer)**:**

FIRST DAY OF EVENT / TOUR:

It is mandatory that the examinee answer the following:

1) Date of Birth:_____ Age:_____ Sex: M / F

2) Please circle the applicable letter if, to the best of your knowledge, you have ever had, been advised you had, been treated for or consulted a doctor regarding any of the following medical conditions:

   a. Convulsions, paralysis or stroke, severe headaches or diseases of the brain or nervous system.
   b. High blood pressure, heart attack, angina pectoris or any other disorders of the heart or blood vessels.
   c. Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs or respiratory system.
   d. Duodenal or gastric ulcer, colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas or gallbladder.
   e. Sugar, albumin, blood or pus in urine, kidney stones or any other disorder of the bladder, kidney or genito-urinary system.
   f. Diabetes, gout or any other disease or abnormality of the thyroid or other glands.
   g. Any disease, disorder or injury of the bones, joints, muscles, back, spine or neck.
   h. Cold sores on lips or face in the past five years.
   i. Any significant change of weight, (20lbs / 10kgs or more) in the past year.
   j. Treatment for or indication of excessive use of alcohol or drugs.
   k. Any infection or disease of the eyes, ears, nose or throat.
   l. Any eating disorder.
   m. Disorder of the skin, lymph glands, cyst, tumour or cancer.

3) To be completed, if examinee is female. To the best of your knowledge:

   a. Have you had any disorder of menstruation, pregnancy or of the female organs or breasts?

      YES ☐ NO ☐

   b. Are you now pregnant?

      YES ☐ NO ☐

   If yes, how many months? _____

4) In the past five years have you been under a doctor's care and / or been admitted to hospital for any physical or psychological condition other than minor ailments (e.g. cold / flu)?

   YES ☐ NO ☐

   If yes, please give details:

5) Are there any other conditions, medical or otherwise, that might affect, or have affected, your ability to perform your duties for this, or any previous event / tour?

   YES ☐ NO ☐

   If yes, please give details:

6) When did you last receive a complete physical examination?

   What were the results?

7) Name and address of personal physician:

8) Do you have any beliefs that preclude you from taking prescribed medication or treatment?

   YES ☐ NO ☐

9) Are you currently using or in the last twelve months have you used:

   a. Prescription or non-prescription drugs?

      YES ☐ NO ☐

   b. Narcotics, depressants, anti-depressants, stimulants, or psychedelic drugs (e.g. LSD), heroin or cocaine, whether prescribed by a physician or not?

      YES ☐ NO ☐

   Please explain any "YES" answer under a. or b. above:

c. Tobacco? YES □ NO □ Amount / Frequency

d. Alcohol? YES □ NO □ Amount / Frequency

10) Will you be participating in any potentially hazardous activities or sports in your personal time between today's date and completion of event / tour, including, but not limited to, auto / motorcycle racing, equestrian, gliding, flying, skydiving, mountain climbing, scuba diving, snow or water skiing, contact sports or other (please specify)?

YES □ NO □

If so, please state frequency (daily, weekly etc.)

11) Has any insurance company declined to insure you or imposed any special terms in regard to your acceptance for any Cast Insurance, Non Appearance Insurance or Accident, Health or Life Insurance?

YES □ NO □

If yes, please explain:

12) Do you have any family history of heart or kidney disease or diabetes?

YES □ NO □

13) Will you be performing any special physical activities during this event / tour?

YES □ NO □

I declare and affirm that I am the person named on this form; that the statements made hereon by me are true, correct and complete; that I have withheld no information known to me which might alter or conflict with the statements made by me. I understand that an insurance policy may be issued and claim settlements made based upon the representations and facts stated by me as true. In the event an insurance policy is issued and a claim is paid, I understand that the Insurer will hold me fully and personally liable and will seek recoupment from me if it is determined that the facts stated herein are not true, correct or complete or that I withheld information which conflicts with the statements I made. I also agree to be re-examined by the Insurer's doctor in the event a claim is made.

I authorise any physician, practitioner, hospital, clinic, laboratory, other medical facility or health care provider, insurance or reinsurance company having information regarding diagnosis, treatment and prognosis of any medical or psychological condition, care and / or treatment to permit the Insurer or its duly authorised representative to review and copy all medical reports, X-rays, charts, records and other data which may pertain in any manner to my medical history, physical or psychological condition, care and / or treatment. I understand that the medical information obtained will be used by the Insurer for underwriting and claim settlement purposes. I agree that this authorisation for release of medical information shall be valid until a claim relating to the examinee has been settled and closed with the Assured. A copy of this form shall be considered as valid as the original and I understand that I may obtain a copy of this authorisation if I so request it.

SIGNATURE OF EXAMINEE OR LEGAL GUARDIAN **DATE SIGNED**

PHYSICIAN'S EXAMINATION

Notes for Physician

Please note that this Medical Questionnaire will be used by insurers to provide a quote for an insurance policy which covers losses caused by the inability of the Examinee to fulfil their required duties on the Event / Tour detailed in the itinerary provided by the Examinee. This is not a Medical Questionnaire for a policy of life insurance therefore Physician's should assess the overall capability of the Examinee to fulfil their obligations on the Event / Tour.

Name of Examining Physician:

Physician's Qualifications and Area of Practice:

Physician's Telephone Number:

Physician's Email Address:

Artist Name:

ARTIST'S GENERAL APPEARANCE

HEIGHT:	WEIGHT:	TEMP.:	BLOOD PRESSURE:
PULSE:	EENT:	HEART:	LUNGS:

If examinee is under the age of fourteen, please advise what childhood disease(s) he / she has had and provide immunisation records:

Please provide details regarding any circled items per Question 2, items a to m (inclusive), or any "YES" answer for Questions 3 to 13 (inclusive) on the examinee's Medical Questionnaire:

Please indicate any vaccinations that the examinee has taken and / or is taking and / or are recommended to be taken for the locations in which the event / tour will take place and, if applicable, for the locations of any other places the examinee intends to visit before or during the period in which the event / tour is taking place:

Please comment on abnormal findings arising from the Medical Questionnaire or Examination:

In the event of any abnormal findings arising from the Medical Questionnaire or Examination please advise of any further tests which you would recommend.

I have performed a medical examination on the examinee prior to today.

YES ☐ NO ☐

I have today examined the above named examinee and in my opinion he / she is in sound health and free from disease and is in a fit condition, subject to any qualifications made above, to fulfil his / her professional engagement.

YES ☐ NO ☐

SIGNATURE OF PHYSICIAN **DATE SIGNED**