



# Emergency Information (page 1 of 2)

Please complete page 2

<b>Student's Name:</b>			
Date of Birth mm/dd/yyyy	Age	Student Home phone	Student Cell Phone
Street Address			Apt. # (if not applicable write "N/A")
City		State	Zip Code

Parent/Guardian #1 Name:	Cell Phone	Work Phone
Parent/Guardian #2 Name:	Cell Phone	Work Phone

<b>Emergency Contact #1 (other than parent)</b>		
Home Phone	Cell Phone	Work Phone
<b>Emergency Contact #2 (other than parent)</b>		
Home Phone	Cell Phone	Work Phone
Participant's Medical Plan	Insurance Number	
Physician	Phone Number	
Dentist	Phone Number	

The following information is important to understand the needs of the student and will not be used in a discriminatory manner:

**Please indicate if the student has any physical or medical needs:**

☐ None    ☐ Unknown    ☐ Traumatic Brain Injury    ☐ Visual Impairment    ☐ Developmental

☐ Allergies (please specify): \_\_\_\_\_

☐ Other (please specify): \_\_\_\_\_

**Has the student received counseling or emotional support in the past?**    ☐ Unknown    ☐ No    ☐ yes

If yes, please specify: \_\_\_\_\_

**Does the student have an IEP?**    ☐ No    ☐ yes

If yes, describe the reason/ diagnosis: \_\_\_\_\_

**Is the student currently receiving counseling or emotional support?**    ☐ No    ☐ yes

If yes, describe the reason/ diagnosis: \_\_\_\_\_



# Emergency Information (page 2 of 2)

Please complete page 1

May your child be given the following if needed?

Aspirin or Tylenol  
☐ Yes ☐ No

Benadryl?  
☐ Yes ☐ No

Has the child had any of the following?

<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Mumps	<input type="checkbox"/> Colds
<input type="checkbox"/> Measles	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Headaches
<input type="checkbox"/> German measles	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Fainting
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Constipation
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Stomach upset
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Asthma	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Nosebleed

List **year** of last immunization or booster

Tetanus	Diphtheria	Whooping cough
Polio	Mumps	Measles
German measles		

## Medical Authorization

Should it be necessary for the student, parent(s), and/or guardian listed above to receive medical care while participating with Red Note Youth Orchestra and/or any activities with which it is affiliated, I/we hereby give Red Note Youth Orchestra personnel permission to use their judgment in obtaining that care. I/We also give permission to the physician selected by Red Note Youth Orchestra personnel to render medical care that s/he deems necessary and appropriate. I/We understand that Red Note Youth Orchestra has no insurance covering medical or hospital costs incurred by any participant and, therefore, any cost incurred for such treatment will be entirely my/our responsibility.

\_\_\_\_\_  
**Parent/Guardian #1 Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian #2 Signature**

\_\_\_\_\_  
**Date**

**RED NOTE YOUTH ORCHESTRA** DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, GENDER, RELIGION, NATIONAL ORIGIN, OR ETHNICITY IN STUDENT ADMISSIONS OR IN ANY PROGRAMS IT ADMINISTERS.