**Musician’s Name:**

**Ensemble(s): Please check all that apply.**

- __ Symphony Orchestra
- __ Repertory Orchestra
- __ String Orchestra
- __ Concertino Strings
- __ Wind Orchestra
- __ Youth Jazz Orchestra
- __ Repertory Jazz Orchestra
- __ Youth Percussion Ensemble
- __ Repertory Percussion Ensemble
- __ Chamber Percussion Ensemble
- __ Concertino Woodwind Choir
- __ Concertino Brass Choir
- __ Concertino Percussion
- __ CHIME at Proctors
- __ CHIME at Yates
- __ CHIME at Van Corlaer
- __ Melodies of Christmas Chorale

**General Permission**

In signing this form I give permission for my child to participate in the Empire State Youth Orchestra. This includes all activities and experiences associated with the program including the Frost Valley Weekend Retreat (Symphony Orchestra & Repertory Orchestra members only). I have received information regarding rehearsal/concert schedule as well as the cost of tuition and I agree to the payment terms.

**Parent/Student Handbook**

I/We the undersigned acknowledge receipt of the ESYO Parent/Student Handbook and agree to the policies and procedures listed within.

**Musician’s Personal Commitment**

I accept membership in the ESYO ensemble(s) offered to me by ESYO. By accepting this offer I certify that I have read the attendance and behavior rules and policies for members, published in ESYO’s handbook and I agree to abide by the policies and rules outlined therein.

**Parent/Guardian’s Certification**

I certify that I am the parent/guardian of the musician referenced in the registration form and that he/she accepts membership in the ensemble offered to him/her by ESYO. My child and I have read attendance rules, behavior rules and policies for members, published in ESYO’s handbook and we agree to abide by the policies and rules outlined therein.

**Waiver of Publicity**

I/We, the undersigned, give permission for the use of any photos, movies, and audio or video tapings of the Minor’s activities. The materials so obtained may be employed with the Empire State Youth Orchestra approval for educational purposes, media coverage, or for publicity benefiting ESYO. I/We also acknowledge that ESYO cannot control photography/filming between students. ESYO cannot be held responsible nor liable for the publication of material created that may contain images of ESYO musicians and/or posted by anyone without ESYO’s knowledge or authorization.

Symphony Orchestra & Chorale: Melodies of Christmas concerts are recorded and broadcast over CBS6/WRGB on Christmas Eve and Christmas Day. In order for your child to participate in Symphony Orchestra/Chorale, you must agree to the following photo release statement: I give permission for my child’s image to be included in any recording of the rehearsals or concerts for use in the TV broadcasting of or any and all promotional materials for the Melodies of Christmas concerts.

___ Yes, I give permission.  ___ No, I do not give permission
**Carpool**

ESYO does not make carpooling arrangements but can facilitate interest by providing your contact information with other families. Please indicate whether you would like to be added to the carpool distribution list. ESYO does not assume any liability for carpooling.

___ Yes, I would like to be added to the carpool list. ___ No, Please do not share my information

**Text Message Notifications**

I consent to ESYO contacting me by text message on my provided cell phone. I understand the text message function is only for the purpose of urgent or emergency notifications, i.e. canceled rehearsal due to inclement weather. Text message charges from my cell phone provider may apply. My signature below indicates that I represent

<table>
<thead>
<tr>
<th>Student</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian 1</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Parent/Guardian 2</td>
<td>Cell Phone</td>
</tr>
</tbody>
</table>

___ No, I do not consent to text messages.

**Emergency Contact, Health Information, and Authorization for Medical Treatment**

By signing this form, I give permission for my child to receive treatment by a qualified physician in the event of an accident or serious illness, assuming ESYO has made every attempt to contact me. I agree to reimburse ESYO for any such treatment and/or related expenses incurred on my child's behalf during any ESYO event. I release ESYO, its officers, agents, and employees from any liability related in any way to this authorization.

<table>
<thead>
<tr>
<th>Musician's Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age as of 9/1/19</td>
<td>Date of last tetanus shot</td>
</tr>
<tr>
<td>Health Insurer</td>
<td>Policy/Group No.</td>
</tr>
<tr>
<td>Mother/Guardian Name</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City/State/Zip</td>
</tr>
<tr>
<td>E-mail</td>
<td>Cell Phone</td>
</tr>
<tr>
<td></td>
<td>Day-Time Phone</td>
</tr>
<tr>
<td>Father/Guardian Name</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City/State/Zip</td>
</tr>
<tr>
<td>E-mail</td>
<td>Cell Phone</td>
</tr>
<tr>
<td></td>
<td>Day-Time Phone</td>
</tr>
</tbody>
</table>
Health Conditions (Please check at least one)

- No health conditions
- Asthma
- Convulsions/Seizures
- Diabetes
- Fainting
- Frequent Nose Bleeds
- Heart Condition
- Low Blood Sugar
- Migraines
- Neurological/Developmental Condition
- Psychological Condition

There is a confidential matter I wish to discuss privately. Please contact me.

Other:

Vision Impairment (Please check at least one)

- No vision impairment
- Student wears glasses
- Student wears contacts
- Other:

Allergies (Please check at least one)

☐ No allergies

☐ Food

☐ Medications

☐ Bee Stings/Insects

☐ Other

Do any of the above allergies require Epi-pen? ☐ Yes ☐ No

If yes, does student carry Epi-pen? ☐ Yes ☐ No

If student does not require Epi-pen, please outline assistance needed if allergy is triggered:

__________________________________________________________________________________________________________________________________________________________

Medication/Purpose/Special Instructions

A. Does the student have any condition that requires daily medication? ☐ Yes ☐ No

Please list the medication or inhalers:

__________________________________________________________________________________________________________________________________________________________

B. Does the student require any medication or inhalers on an as needed basis? ☐ Yes ☐ No

Please list the medication or inhalers:

__________________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________________
C. If requested by student, chaperones and staff have permission to dispense the following medication:

__ Benadryl (Antihistamine)  __ Tums (antacid)
__ Dramamine (Antivert/Motion sickness)  __ Tylenol (Acetaminophen)
__ Advil (Ibuprofen)

Food Restrictions (Please check at least one)

__ No food restrictions  __ Halal  __ No red meat
__ No food allergies  __ Lactose Intolerant  __ Vegetarian
__ Gluten-free  __ No nuts  __ Vegan
__ Kosher  __ No shellfish

☐ __ Food Allergy

☐ __ Special Diet

Student Name (Please Print)

________________________

Student Signature       Date

Parent/Guardian Name (Please Print)

________________________

Parent/Guardian Signature       Date