2019 MELODIES OF CHRISTMAS CHORALE

Musician's Name: ____________________________________________________________

General Permission
In signing this form I give permission for my child to participate in the Empire State Youth Orchestra’s Melodies of Christmas Chorale. I acknowledge I have received information regarding rehearsal/concert schedule for Melodies of Christmas.

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.

Melodies of Christmas concerts are recorded and broadcast over CBS6/WRGB on Christmas Eve and Christmas Day. In order for your child to participate, 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

__________________________________________________________________________________________________

Student       Cell Phone

__________________________________________________________________________________________________

Parent/Guardian 1       Cell Phone

__________________________________________________________________________________________________

Parent/Guardian 2       Cell Phone

___ 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.

Musician’s Name

Age as of 9/1/19

Date of last tetanus shot

Health Insurer

Policy/Group No.

Mother/Guardian Name

Street

City/State/Zip

E-mail

Cell Phone

Day-Time Phone

Father/Guardian Name

Street

City/State/Zip

E-mail

Cell Phone

Day-Time Phone

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

☐ __ Food Allergy

☐ __ Special Diet

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**Student Name (Please Print)**

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Student Signature       Date

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**Parent/Guardian Name (Please Print)**

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Parent/Guardian Signature       Date