

# 2019/2020 SEASON CONSENT FORMS



Please return signed to ESYO, 432 State Street,  
Schenectady, NY 12305 by August 1, 2019.

## 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)
- Dramamine (Antivert/Motion sickness)
- Advil (Ibuprofen)
- Tums (antacid)
- Tylenol (Acetaminophen)

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