

**METROPOLITAN YOUTH SYMPHONY
SEASON MEDICAL FORM**

Name (Please Print) _____ Today's
Date _____
Age _____ Date of Birth _____ Male _____ Female _____ Grade in School in
September '07 _____

Address _____ City _____ State _____
Zip Code _____

I give permission for (Please Print) _____, a
member of the
Metropolitan Youth Symphony, to receive any medical treatment as deemed necessary
by an adult representative of MYS, should a medical emergency occur. I understand
that I am responsible for all expenses associated with the above medical treatment. All
reasonable efforts will be made to reach me should an emergency occur. This
authorization is in effect for the duration of the current MYS season.

Print Name _____ Signature _____

Phone Number(s) _____ Relationship to MYS Musician _____

Family Physician: _____
Phone: _____
Group Number: _____ ID
Number: _____
Insurance Company: _____
Employer: _____

IMMUNIZATIONS

Is your child's Tetanus immunization current (should be within 10 years)?

_____ Has your child had chicken pox? YES ___ NO ___ if no, has he/she had the Varicella
vaccine? Y ___ N ___

Are your child's other immunizations current? YES _____ NO _____ if no,
why _____

Current medications of which MYS should be
aware: _____

Chronic
Illnesses: _____

Please list any known allergies to foods, prescription or OTC medications, plants, etc. REGARDLESS OF SEVERITY. Specify type of reaction and treatment (use other side of form, if necessary): _____

Any other medical or personal information of which MYS should be aware? _____

In case of an emergency, please notify the following persons in order, as listed:

1. Name _____
Relationship _____
Phone: Home _____ Work _____
Cell _____
Email _____
Address: _____

2. Name _____
Relationship _____
Phone: Home _____ Work _____ Cell _____
Email _____
Address: _____

3. Name _____ Relationship _____
Phone: Home _____ Work _____
Cell _____
Email _____
Address: _____
