GREENSBORO SYMPHONY YOUTH ORCHESTRA HEALTH FORM

NAME (Last, First, Middle):	**Parent/Guardian:**	**Phone # Home:**

Address	**City**	**State**	**Zip**	**Birth date:** **Sex:**	**Age:**

Emergency Contact: **Phone#** **Home:**

Cell:

Health History: (check all that apply)

Allergies/Intolerances:	**Chronic/Recurring Illnesses:**	**Recent illness or injury:**
( ) Food: _____	( ) Asthma_____	_____
( ) Environmental: _____	( ) Diabetes_____	_____
( ) Drug: _____	( ) Epilepsy/Seizures_____	_____
( ) Headaches_____	( ) Other_____	

Special medical or dietary regimen to be followed: (please specify) _____

Comment where applicable:

( ) Fainting_____( ) Motion Sickness_____ ( ) Nosebleeds_____ ( ) Contacts_____

( ) Glasses_____ ( ) Sleep Disturbances_____ ( ) Other_____

Over the Counter Medications: my child has permission to take or use the following medications:

( ) Tylenol/Acetaminophen ( ) Advil/Motrin/Ibuprofen ( ) Pepto-Bismol (( ) Tums/antacid ( ) Sudafed/Decongestant

( ) Benadryl/Antihistamine ( ) Robitussin/Expectorant ( ) Natural Tears/Eye Drops

Name of Physician: _____ **Phone#:**_____

Medications: If any student needs to possess medications during any GSYO activity or trip, then the medication(s) must be clearly labeled and in their original containers. If medications are to be administered, please indicate (comments) who will administer medications: student or lead chaperone (who will not be a healthcare professional). Use back of page if necessary.

MEDICATION	**DOSE**	**FREQUENCY**	**COMMENTS**
1.			
2.			

Parents of GSYO Student Musicians: I hereby authorize any medical treatment for my son or daughter as may be recommended by a licensed health care provider. I further authorize the dispensing of over the counter medications as indicated above, and the administering of other medications as set forth above. GSYO has my permission to transport my son or daughter to a hospital or doctor for medical treatment should there be an illness or injury. I understand that GSYO does not provide any trained health professionals in connection with its activities, and I do not rely on GSYO to do so.

SIGNATURE OF PARENT OR GUARDIAN: _____ **DATE:** _____