FORT WORTH YOUTH ORCHESTRA

Student Health Information Form

Student Name: _____ DOB: _____ Instrument _____
Address:_____
FWYO Program: Grade: _____ School _____

Parent/Guardian: _____ Relationship to Student: _____
Phone: (Best # during rehearsal): _____(alt. #): _____E-mail: _____
Parent/Guardian: _____ Relationship to Student _____
Phone: (Best # during rehearsal): _____(alt. #): _____E-mail: _____

Alternate contacts to call in case of an emergency and parents/guardians cannot be reached:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Physician Name: _____ Phone: _____ Preferred Hospital: _____
Student's Health Insurance:_____

Indicate if your child has any of the following health conditions:

ADD/ADHD	☐	Cystic Fibrosis	☐	Migraine Headaches	☐
Allergy: Food**	☐	Diabetes	☐	Muscular/Orthopedic Disorder	☐
Allergy: Insect Bite/Sting	☐	Eating Disorder	☐	Psychiatric/Psychological Disorder	☐
Allergy: _____	☐	Epilepsy/Seizures	☐	Special Needs	☐
Asthma	☐	Hearing Condition	☐	Vision Loss-not corrected with glasses/contacts	☐
Blood Disorder	☐	Heart Condition	☐	Chicken Pox-month/day/year _____	☐
Cerebral Palsy	☐	Kidney Disorder	☐		

If you checked any of the boxes above, or if your child has medical conditions not listed, please explain (including **specific food, medication or other serious allergies and reactions)**: _____
_____
_____
_____
Past history of injuries/illnesses/hospitalizations/surgeries: _____
_____

Please list all medications your child is currently taking:

Medication Name _____ Dose _____ Reason_____

Medication Name _____ Dose _____ Reason_____

Medication Name _____ Dose _____ Reason_____

It may be necessary for FWYO personnel to apply topical first aid medications such as: anti-itch cream, antibiotic ointment, tooth pain gel, saline eye drops. If you do not want your child to receive these services enter "no" on the line following. Otherwise it is understood that you are giving permission for FWYO personnel to apply first aid medications. ____

I, the undersigned, do hereby authorize officials of the Fort Worth Youth Orchestra to contact alternative adults and physicians listed. I authorize trained personnel to render treatment deemed necessary in case of an emergency. I authorize medical information to be shared with appropriate personnel. I will not hold Fort Worth Youth Orchestra financially responsible for the emergency care and/or transportation of said child.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**