DOUGLAS COUNTY YOUTH ORCHESTRA

Student/Participant Information Sheet 2025 - 2026 Season

(Please complete form in its entirety)

Student/Participant Name: _____ _____ **Age:** _____
First **Last**

Gender: Male [ ] Female [ ] Other: _____ Pronoun preference: _____ **School Grade Level**: _____

Primary Instrument: _____ **Private Instructor:** _____**Years Played**: _____

Shirt Size: _____ **Other Instruments:** _____

Other Music Groups? _____

Life Threatening Allergies? Yes [ ] No [ ] If yes list allergies:

_____Care:_____

Medical Conditions we should know about:

_____Care:_____

Anything other needs or concerns we should know about you Child?

_____

Contact Information:

Parent: (primary contact)

Household Name: _____

(eg: The Smiths. Please use the same household name if filling out multiple forms for students in your household. This will be the household name used on future e-documents)

Parent E-mail: _____ **(Print clearly)**

(Primary Contact: This will be the email address used for e-documents)

Parent Name: _____ _____
First **Last**

Mobile _____ Primary phone? Yes [ ] Home Phone _____ Primary phone? Yes [ ]

Other/Work Phone _____ Primary phone? Yes [ ]

Address: _____

City: _____ State: _____ Zip_____

Participant/Student:

Student **E-mail**: _____ **(Print clearly)**Student Phone: _____ Mobile? [ ]

Address same as parent #1? Yes [ ] No [ ]

Address: _____

City: _____ State: _____Zip_____

Parent2:

Parent 2 **E-mail:** _____ **(Print clearly)**

Parent 2 Name: _____ _____
First Last

Mobile _____ Primary phone? Yes [ ] No [ ] Home _____ Primary phone? Yes [ ] No [ ]

Other/Work Phone: _____ Is primary phone? Yes [ ] No [ ]

Other Contact info:

Other **Email**: _____

How did you hear about us? _____

DOUGLAS COUNTY
YOUTH ORCHESTRA

Medical Form 2025 - 2026 Season

(Please complete form in its entirety)

Dear Parents/Legal Guardians,

All participants must have a medical form on file with Douglas County Youth Orchestra.

Participant/Child's name: _____ _____Age:___Birthdate:___/____/_____
(MM/DD/YYYY)

Parent(s)/LegalGuardian(s):_____
Home Phone: _____ Mobile Phone: _____ Other/Work Phone: _____

Health Insurance Company: _____

Group/ID #: _____ /_____
Group # ID#

I/we, the parent(s) or legal guardian(s) of _____(minor), hereby grant my/our permission for the use of emergency medical treatment, provided by licensed medical authority and, in the opinion of such medical authority, if deemed necessary for the health and safety of said minor. It is understood that every attempt will be made to notify me immediately by telephone of any such emergency. I/we understand that I/we are responsible for all expenses associated with any such medical treatment. **I/we expressly agree that DCYO will not be held responsible or in any way liable for the medical care provided by such medical authority.**

Emergency Contacts: In the event of an emergency and I/we cannot be reached, please contact the person named below for instructions. (Emergency Contacts should **not be** the Parent/Guardian listed above and should be a Colorado Resident)

Emergency Contact 1:

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____ Other/Work Phone: _____

Emergency Contact 2:

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____ Other/Work Phone: _____

_____ Signature of Parent/Legal Guardian
Signature of Parent/Legal Guardian