



Student/Participant Information Sheet 2020 - 2021 Season
(Please complete form in its entirety)

Student/Participant Name: _____

First

Last

Gender: Male Female Other: _____ **Pronoun preference:** _____

Primary Instrument: _____ **Years Played:** _____ **Shirt Size:** _____

Other Instruments: _____

Private Instructor: _____ **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? _____



Medical Form 2020 - 2021 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)/Legal Guardian(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

Permission to use Audio/Visual Images

Name _____ Instrument _____ I agree to allow pictures of my child to be used for marketing/website purposes.

Yes: ____ No: ____ Date: _____

Parent Name (or student name if 18 or older) PLEASE PRINT

Parent Signature (or student signature if 18 or older)