



GREENSBORO YOUTH CHORUS

# Travel Release

2009-2010

Circle Choir

GCC

CHL

CTB

## Travel Release & Waiver

I give permission for my child, \_\_\_\_\_, to travel with the Greensboro Youth Chorus. Recognizing that some risk may be involved in traveling with the Greensboro Youth Chorus, the undersigned hereby releases the Greensboro Youth Chorus, its staff, directors and agents from all risks involved in this activity, and from all claims arising from participation in this activity. I further state that I maintain current medical and/or accident insurance coverage as follows:

Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

## Authorization of Consent to Medical Care for Minor

I, \_\_\_\_\_, of \_\_\_\_\_ County, State of \_\_\_\_\_, am the custodial parent having legal custody of \_\_\_\_\_, a minor child, age \_\_\_\_\_, born on \_\_\_\_\_.

I authorize the directors of the Greensboro Youth Chorus and parent chaperones, adults in whose care the minor child has been entrusted, to do any acts which may be necessary or proper to provide for the medical care of the minor child, including, but not limited to, the power to provide for such care at any hospital or other institution, or the employing of any physician, dentist, nurse or other person whose services may be needed for such care. I consent to and authorize any medical care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists and other medical personnel except for the withholding or withdrawal of life-sustaining procedures. I hereby release the Greensboro Youth Chorus and its directors and/or other agents from any liability for such needed care. I indemnify and hold blameless the Greensboro Youth Chorus, its directors, and other agents for the cost of any such needed care.

I consent to the administration of over-the-counter medications such as Tylenol, Advil and Tums or their generic equivalent to the minor child by the director or parent chaperone. I state that the minor child is not allergic to such medications.

By signing below, I indicate that I have the understanding and capacity to make medical decisions for the minor child and that I am fully informed as to the contents of this document and understand the full import of this granting of powers to the agents named herein.

Custodial Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed by: \_\_\_\_\_



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# Medical Information

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## Contact Information

Name of Minor Child \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Birth date \_\_\_\_\_

City, State & Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Mother's/Guardian's Name \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_

Father's/Guardian's Name \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_

Family Doctor/Pediatrician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## Travel Information (Circle Yes or No)

Traveled overnight before? Y or N    Without Parents?    Y or N    Been very homesick? Y or N

Traveled by boat before?    Y or N    Traveled by airplane? Y or N    Strong swimmer?    Y or N

## Medical Information

My child has experienced: fainting, dizziness, seizures, motion sickness, chronic problems, none

Other \_\_\_\_\_

Allergies or reactions to medications: \_\_\_\_\_

Any other allergies? (food, flowers, materials, dyes, stings, cigarette smoke, etc.): \_\_\_\_\_

Date of last Tetanus Shot: \_\_\_\_\_

Special medical needs: \_\_\_\_\_

Special dietary habits or needs: \_\_\_\_\_

Conditions requiring medications: \_\_\_\_\_

Medication	Dosage Amount	Dosage Time(s)	Comments/Instructions