



New Jersey Youth Symphony  
 570 Central Avenue Murray Hill, NJ 07974  
 (908) 771-5544 Telephone  
 (908) 771-9839 Fax  
 www.njys.org

## MEDICAL FORM

Please complete both sides of this form

Student Name: \_\_\_\_\_ Ensemble: \_\_\_\_\_

In the absence of a parent or legal guardian of the student named above, and in the case a parent or legal guardian cannot be contacted, in the event of an emergency, the Undersigned parent or legal guardian authorizes NJYS to take such measures and arrange for such medical and hospital treatment as is deemed necessary and appropriate to protect the health and well-being of the student named above. NJYS is also authorized, in the event of an emergency, to permit necessary surgery or medicine application as advised by a physician or medical staff, or to take the student named above to the emergency room of the nearest hospital. Further, the Undersigned authorizes that hospital and its medical staff to provide necessary and appropriate surgery and medical treatment to restore well-being to the student named above. The Undersigned agrees to indemnify and hold harmless NJYS, its employees and representatives against any action resulting from negligence or accidental transgressions while performing under this authorization.

Parent or Guardian Signature: \_\_\_\_\_

Print Parent or Guardian Name: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact #1 (Name & Telephone): \_\_\_\_\_

Emergency Contact #2 (Name & Telephone): \_\_\_\_\_

### Emergency Medical Information

Please check all that apply

\_\_\_ Allergies to food/medication/other causes. Explain below and/or attach additional page)

\_\_\_ Dizzy spells, motion sickness, fainting

\_\_\_ Heart trouble or chest pains

\_\_\_ Frequent nausea, jaundice, hepatitis

\_\_\_ Diabetes

\_\_\_ Frequent headaches

\_\_\_ Emotional problems that require medication

\_\_\_ Hypoglycemia

\_\_\_ Chronic back or neck pain

\_\_\_ Low/high blood pressure

\_\_\_ Asthma

\_\_\_ Hernia, severe menstrual cramps

\_\_\_ Convulsions

\_\_\_ Epilepsy (seizures)

\_\_\_ Major bone or joint injuries

(over)

Explain any checks or other concerns below and/or attach additional page:

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Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

May NJYS contact your physician if there are any medical concerns?    \_\_\_ Yes        \_\_\_ No

Health/accident insurance carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

### **Immunization Records**

Immunization record information is required under NJ State Law. It is extremely important to include dates. You must attach a copy of your immunization records from your pediatrician. Please note that your child will not be allowed to participate without this information. Also, without dates on ALL required immunizations, the medical form will not be valid for our records. (Please give date of last inoculation).

Has your child had Chicken Pox:        \_\_\_ Yes                \_\_\_ No

Is the child currently under medical care, experiencing any medical conditions that require special attention, or taking medication? \_\_\_ Yes        \_\_\_ No

If yes, explain below:

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