



Waiver and Release for Westchester Suzuki Institute (sponsored by Hudson River School of Music)

Liability Release and Parental Consent Form

In consideration of the acceptance of my application for the above program, I hereby waive, release, and discharge any and all claims for damages for personal injury, property damages or which may hereafter occur to me as a result of participation in said event. This release is intended to discharge in advance Westchester Suzuki institute and Hudson River School of Music, its officials, officers, employees, volunteers and agents for liability, even though that liability may arise out of perceived negligence on the part of persons mentioned above. It is understood that some recreational activities involve some risk or danger of accidents, and knowing those risks, I hereby assume those risks. It is further understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs and assignees.

Parental Consent

I give consent for my child _____ to participate in the above activities, and I execute the above liability release on their behalf.

Consent for Treatment

I hereby give my consent to have the above applicant treated by emergency medical personnel, a physician, or surgeon, in case of sudden illness or injury while participating in the above activity. It is understood that Hudson River School of Music will provide no medical insurance for such treatment, and that the cost thereof will be at my expense.

I have read and understood the foregoing registration liability release and parental consent form, and agree to all of its terms and conditions.

Parent/Guardian Signature

Print Name

Date

Student Signature

Print Name

Date

Westchester Suzuki Institute Medical Information

Child

First _____ Middle _____ Last _____

Gender: Male __ Female__

Birth date ____/____/____ Age (as of June 27, 2020) _____

Street Address _____

Town/City _____ State _____ Zip code _____

Child's Home Phone _____

Parent/Guardian - Contact Information

Parent/Guardian #1

First _____ Last _____ Ms. Mrs. Mr. Other _____

Street Address _____

Town/City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell phone _____ E-mail _____

Occupation _____ Employer _____

Parent/Guardian #2

First _____ Last _____ Ms. Mrs. Mr. Other _____

Street Address _____

Town/City _____ State _____ Zip code _____

Home Phone _____ Daytime phone _____

Cell phone _____ E-mail _____

Occupation _____ Employer _____

Child lives with: _____

Person responsible for payment _____

Emergency Contact Information – Alternate Pickup/Release

Emergency Contact #1

First Name _____ Last Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Relation to child _____

Emergency Contact #2

First Name _____ Last Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Relation to child _____

Please list those people in addition to parents/guardians who are permitted to pick up your child:

1: _____ 2: _____ 3: _____

Medical Release Information

Insurance Information

Policy Number _____

Name of Health Insurance Provider _____

Primary Physician _____

Address _____

Phone _____ Hospital Preference _____

Please list any medical problems, including any requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

<u>Medical Problem</u>	<u>Required treatment</u>	<u>Should paramedic be called?</u>
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

Is your child presently being treated for an injury or sickness, or taking any form of medication for any reason?
Yes__ No__ If yes, explain: _____

Is your child allergic to anything - food or medication?

Yes__ No__ If yes, explain: _____

Does your child require a special diet?

Yes__ No__ If yes, explain: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

In case of medical emergency contact:

	Name	Phone #	Relationship to Child
Contact #1			
Contact #2			
Contact #3			

I understand that I will be notified in the case of a medical emergency involving my child. In the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

Parent's/Guardian's Initials _____



**Immunization Report
(Physician-provided Immunization Report also acceptable)**

Student's Name _____

Date of Birth _____

	#1	#2	#3	#4	#5
*DPT/DTaP/DT					
*Polio					
*MMR (1 st given after 1 st birthday)					
*Hep B					
*Varivax					
*Hib (H influenza)					
*Measles					
*Mumps					
*Rubella					
Td (Tetanus/diphtheria toxoid)					
*Tdap booster					
PPD					
BCG					
Meningococcal					
Hep A					
Human Papillomavirus (HPV)					
Pneumococcal					
Date of chicken pox disease					

*** Required by New York State Law**

Physician's Signature _____

Date _____

Healthcare provider stamp