

EMERGENCY MEDICAL INFORMATION
SHENANDOAH SUMMER FLUTE WORKSHOP

Please complete a form for EACH registered student. Please **PRINT** clearly.

Student Name: _____
Date of Birth: _____ Home Phone: _____
Mother's Name/Work Phone: _____
Father's Name/Work Phone: _____

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If a parent cannot be reached in an emergency, please call:

Name/Relationship: _____
Daytime Phone: _____
Doctor's Name/Phone: _____
Health Insurance Company: _____
Policy Information: _____

Please describe any ALLERGIES (drug, food, insect sting, etc.):

Please describe all MEDICAL CONDITIONS and SPECIAL NEEDS or CONSIDERATIONS we should know to better support your child while at Institute. Attach a separate sheet if necessary. All medical information will be treated as confidential:

The Summer Flute Workshop Staff has my permission, in an emergency when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital, and the hospital and its medical staff has my authorization to provide treatment which a physician deems necessary for the well-being of my child.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____