# CONFIDENTIAL INFORMATION

**Program:**
MITCH

## Release for Emergency Care

- I hereby give my consent to any emergency facility and/or physician to administer any treatment that such facility or physician may deem necessary or appropriate to my child.
- In the event of an emergency during which I cannot be reached, I give consent to transport by ambulance if the situation warrants it.
- I understand that I will be responsible for all expenses associated with above medical treatment. I will defend, indemnify and hold Hawaii Youth Symphony and its officers, directors, agents, volunteers and attorneys harmless from and against any damages, liabilities, claims, costs or expenses arising from any such medical treatment.

Student Name: _____

Emergency Contact Person: _____ Phone: _____

Physician's Name: _____ Phone: _____

Medical conditions (i.e. allergies, asthma, etc.):

_____

_____

Medications currently taking: _____

Date of last DPT or Tetanus: _____

Medical Insurance Plan Covering Child: _____

Policy Number: _____ Policy Holders Name: _____

_____ _____

Parent/Guardian's Signature & Date Parent/Guardian's Signature & Date

**IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY TO NOTIFY HAWAII YOUTH SYMPHONY OF ANY CHANGES IN THE ABOVE INFORMATION. PLEASE EMAIL ADMIN@HIYOUTHSYMPHONY.ORG**