"KICKIN' BRASS"
YOUTH SEMINAR

July 15-17, 2020
W.K. Kellogg Auditorium

Registration Form

Registration Deadline: May 15, 2020

KICKIN' BRASS YOUTH SEMINAR
REGISTRATION INSTRUCTIONS

General

You must complete all items in the registration form. Please print your answers using either black or blue ink.

Section 1 – Student Information

If you want to be known at the seminar by a nickname, complete that item with the name you prefer. Otherwise put "N/A" in the space for the nickname.

Please indicate the instrument you will be playing at the seminar.

- ☐ Eb Cornet
- ☐ Bb Cornet
- ☐ Flugel Horn
- ☐ French Horn
- ☐ Baritone
- ☐ Euphonium
- ☐ Trombone
- ☐ Bass Trombone
- ☐ Tuba
- ☐ Percussion (Specify _____

This seminar is designed to build on existing skills. Please estimate your skill level on your instrument.

If you are not in a band or orchestra, please list the name of someone who knows your skill level with your instrument.

Please indicate the number of days attending the seminar.

Section 2 – Parent/Guardian Information

The information in this section will help us to know who to contact in case of emergency. Also, you will need the permission of a parent or guardian to attend the seminar.

Section 3 – Health Information

Please alert us to your allergies, especially those that can pose serious health risks such as peanut allergies.

Section 4 – Your Goals

If you have a goal or goals different from the ones listed in this section, please print them clearly below the suggested goals.

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July 15-17, 2020

Section 1 – Student Information

First Name:_____ MI___ Last Name:_____

Date of Birth:_____ Your Instrument(s) :

Grade Fall 2020: _____

Your School:_____

Your Band Director:_____

T-shirt size: _____

Have you attended a prior BBBC Youth Brass Event? Yes [ ] No [ ]

Have you had private lessons on your instrument? Yes [ ] No [ ] If yes, for how many years?_____

Number of years playing your instrument:_____

Estimate your skill level on your instrument: Beginner [ ] Intermediate [ ] Advanced [ ]

If you attended MSBOA District and State Solo & Ensemble, please list your ratings:_____

- ☐ Eb Cornet
- ☐ Bb Cornet
- ☐ Flugel Horn
- ☐ French Horn
- ☐ Baritone
- ☐ Euphonium
- ☐ Trombone
- ☐ Bass Trombone
- ☐ Tuba
- ☐ Percussion (Specify_____)

Days Attending Seminar:

[ ] Wednesday	7-15-20	$ 50.00
[ ] Thursday	7-16-20	$ 50.00
[ ] Friday	7-17-20	$ 50.00

TOTAL DUE: **$ _____**

Section 2 – Parent/Guardian Information

First Name:_____ Last Name:_____ Relationship:_____

Home Address:_____ City and Zip:_____

Email Address:_____ Phone #:_____

Can this person provide transportation for you to the seminar? Yes [ ] No [ ]

Section 3 – Health Information

Insurance Provider:_____ Policy #:_____

List food or other allergies:_____

_____

Family Doctor:_____ Phone #: _____

Section 4 – Your Goals

What are your goals for attending the 2020 Kickin' Brass Youth Seminar? Check all that apply.

Improve my technique [ ] Exposure to new music styles [ ] Meet other good musicians [ ]

Grow as a musician [ ] To be challenged [ ] Make new friends [ ] Excel musically [ ]

Section 5 – Your Thoughts about Attending the Seminar

What do you feel attending the Kickin' Brass Youth Seminar will mean to you?

Your signature

_____ Date: _____

Parent/Guardian signature

_____

Mail completed registration form to: 2020 Youth Seminar, PO Box 556, Marshall, MI 49068

Tuition is due in full with registration form* Any and all tuition refund requests are at the sole discretion of the Brass Band of Battle Creek.

***Financial Aid is available to qualifying registrants. Please indicate if you are requesting Financial Aid here: _____**

CONSENT FOR TREATMENT
Brass Band of Battle Creek

Kickin' Brass Youth Seminar

STUDENT NAME_____BIRTHDATE____/_____/_____
MEDICATION ALLERGIES_____
OTHER ALLERGIES_____

Dear Parent or Guardian:

Please complete and sign this form so that your student may receive medical care if needed while at the BBBC Kickin' Brass Youth Seminar.

I give my permission for (Student's Name) _____to receive medication and/or first aid from Mr. Jerry Rose or his designee. In addition, I give Mr. Rose or his designee permission to seek additional medical care for my child as needed. Every effort will be made to reach the individuals listed below prior to seeking additional care.

I give permission for my child to receive any of the medications listed below as deemed appropriate by Mr. Rose or his designee:

A. Antibiotic ointment
B. Benadryl oral
C. Acetaminophen (Tylenol)
D. Ibuprofen (Advil)
E. Throat Lozenges
F. Dry Tears Saline eye drops (non-medicated)
G. Chewable antacid tablets (Tums)
H. Cortisone cream
I. Antiseptic Wash

I understand that the above medications will be administered by Mr. Rose or his designee in accordance with manufacturer's instructions. I verify that I am authorized to sign this consent for the person named above.

Parent/Guardian Signature_____Date_____

Your child's health information is confidential and only available to the BBBC staff. I permit the BBBC staff to share health information with medical professionals as necessary to provide a safe and positive environment.

Parent/Guardian Signature_____Date_____

Student Health Information

Name _____ Birth date ___/___/___ Grade _____
Last First Middle Initial

Address_____ Phone_____
Street City Zip Code

Does student have health insurance? ___Yes ___No List_____

Doctor's Name_____ Telephone Number _____

Date of last physical _____

Dentist's Name_____ Telephone Number_____

Does student have any of the following?

Allergies Yes ____ No____ To drugs, food, pollen, etc? List _____

Describe reaction _____

Does your child have an EpiPen at YB Seminar? Yes ___ No ___

Bee sting allergy Yes____ No____ Describe reaction _____

Does your student have difficulty breathing when stung? Yes ___No ___

Does your child have a Bee Sting Kit at YB Seminar? Yes ___ No___

Asthma Yes____ No ____ Treatment needed _____ Triggered by_____ Diagnosed by doctor? Yes___ No ____

Uses an inhaler/nebulizer? Yes ___ No ___ Inhaler/nebulizer available at YB Seminar? Yes ___ No ___

Diabetes Yes ____ No ____ Does your child take insulin? Yes ___ No ____

Does your child take oral medication? Yes ___ No ____ List typical range of blood sugar _____

Testing equipment at YB Seminar? Yes ___ No ____

Epilepsy/Seizures Yes____ No____ Describe seizure _____

Medication _____ Last seizure (date) _____

Heart Condition Yes No Describe_____ Physical restrictions?

_____ Medication_____

Had chicken Pox Yes No Date: _____ Vaccine: Yes ___ No ___

List any serious illnesses, surgeries or injuries in the past 12 months:

_____

Eyes: Glasses ___, Contact Lenses ___, Other _____

Ears: Tubes ___, frequent infections ___, Hearing aid ___, difficulty hearing _____ Other (circle those that apply): Headaches, ADD/ADHD, Nosebleeds, Sleeping Problems, Skin Problems, Bladder/Bowel Problems, Blood Pressure Problems, Mental Health Issues, Eating Disorder, Dental Problems, Menstruation Problems, Blood Disorder (for example: sickle disease): Describe: _____

Other health information or concerns: _____

Mother/Guardian _____ Home #_____Work # _____ Father/Guardian

_____ Home # _____ Work #_____ Other Emergency Contact

_____Relationship _____ Phone _____ Parent/Guardian

Signature_____Date_____