



EMERGENCY AND HEALTH INFORMATION

Current Level: []WC1 []WC2 []WC3 []WC4 []WC5 []SR

I. Family Information - To be filled out by parent or guardian. Please print clearly. Today's date _____

Child's first name _____ Middle Initial _____ Last Name _____

Home address _____ City _____ Zip _____

Date of birth _____ Age: _____ Grade in Fall: _____ School: _____ Sex: []M []F
at 9/10 at 9/10 at 9/10

Does child also live at another residence? [] Yes [] No If Yes, please indicate with whom _____

• Primary Email Address: _____

• Chorister's Email Address: _____

• Chorister's Cell Phone #: (_____) _____ Home Phone #: (_____) _____

Table with 3 columns: Parent #1 /Guardian, Parent #2 /Guardian, and various contact fields (Full Name, Street Address, City & Zip Code, Employer, Job Title/Occupation, Day/Business Phone, Evening Phone, Cell Phone, Email).

II. Persons to be contacted if you cannot be reached:

Name _____ Relationship _____ Phone (_____) _____

Name _____ Relationship _____ Phone (_____) _____

III. Family doctor to be contacted in an emergency:

Dr: _____ Phone (_____) _____

Doctor's Fax # (_____) _____

IV. Dentist(s) to be contacted in an emergency:

Dentist: Dr. _____ Phone (_____) _____

Orthodontist: Dr. _____ Phone (_____) _____

V. Health/Accident insurance company name:

Phone (_____) _____

Primary person on coverage _____ Group # _____ Subscriber # _____

Billing address of Insurance Company _____

** Levels 3 & 4 please attach photocopy of both sides of medical insurance card!



VI. Allergies: e.g. food, plants, animals, insects, medicines (if more room is needed, please attach separate sheet)

Explain: _____

Table with 4 columns: Reason/Symptom, Medication, Dosage, Comments

VII. Immunizations: List date of last inoculation (If all other inoculations are NOT up-to-date, please attach an explanation)

Tetanus/Diphtheria mm/dd/yy TB skin test mm/dd/yy Date of Last Physical mm/dd/yy

Parent Signature Date

VIII. Special dietary needs: e.g. Food allergies, Vegetarian, Lactose Intolerant (if more room is needed, please attach separate sheet)

Explain: _____

IX. Medical information, past or present, any conditions CCCC should be aware of: e.g. A.D.D., asthma, nose bleeds, eating disorders, diabetes, convulsions (if more room is needed, please attach separate sheet)

Explain: _____

Please explain in detail below, (e.g. with Asthma, does child carry inhaler?)

Table with 4 columns: Reason/Symptom, Medication, Dosage, Comments

X. Any reason to restrict full activity including swimming, long walks, strenuous physical games? [] yes [] no

List any condition that would limit full participation. (Physical or emotional) _____

Explain _____

XI. Any special equipment such as orthopedic or handicap devices, glasses/ contacts or dentures? [] yes [] no

If yes, list and explain proper usage. _____

XII. Any family issues or concerns you have about your child that CCCC should know? [] yes [] no

Explain _____

In case of Emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I give permission for treatment including hospitalization, anesthesia, surgery, or injections of medication for my son/daughter.

Date: mm/dd/yy Signature _____