EMERGENCY AND HEALTH INFORMATION

Current Level: ☐L1 ☐L2 ☐L3 ☐L4 ☐HONORS ☐SR(P & E)

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 9/11 at 9/11 at 9/11

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 #:*** (_____) ____________________

	Parent #1 /Guardian (if Guardian, please state relationship to child)	**Parent #2 /Guardian** (if Guardian, please state relationship to child)
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!*

Continued . . .

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Contra Costa Children's Chorus

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

Explain: ____

____

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 ____________ TB skin test ______________ Date of Last Physical ____________________
mm/dd/yy mm/dd/yy 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?)

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: ____________ **Signature** ______________________________________
mm/dd/yy