



Student Name: _____

PARENTS

Circle One: Mother/Father/Stepmother/Stepfather/Other (Please specify) _____

First Name: _____ Last Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Circle One: Mother/Father/Stepmother/Stepfather/Other (Please specify) _____

First Name: _____ Last Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMERGENCY CONTACTS (NOT PARENTS)

Primary Contact: Relationship: (Friend/Aunt/Uncle/Neighbor/etc.) _____

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Secondary Contact: Relationship: (Friend/Aunt/Uncle/Neighbor/etc.) _____

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____



Student Name: _____

MEDICAL INFORMATION

Physician:

First Name: _____ Last Name: _____

Address: _____

Phone: _____ Fax: _____

Dentist:

First Name: _____ Last Name: _____

Address: _____

Phone: _____ Fax: _____

Medical Insurance:

Named Insured: _____

Relationship: _____

Group ID/Number: _____

Insured ID/MRN: _____

Medications:

Please list all medications that your child requires, including over the counter medications, listing doses and times taken.

Allergies:

Please list any drug, food, or environmental allergies that your child may have.



Student Name: _____

Medical Conditions:

Please list any medical conditions that may affect your child's participation in the regular choir program, camp, or tour.

Immunization Dates:

DTP _____	MMR _____	H. Influenza B _____
TD _____	Measles _____	Hepatitis B _____
Tetanus _____	Mumps _____	Chicken Pox _____
Polio _____	Rubella _____	BCG _____

TB Test: Date: _____ Results: _____

MISCELLANEOUS INFORMATION

Diet Restrictions:

Please list any diet restrictions (vegetarian, vegan, kosher, lactose intolerant, etc.) that your child may have.

Activity Restrictions:

Please list any activity restrictions that your child may have.

Swim Level: _____ **T-Shirt Size:** _____



Student Name: _____

**THIS SECTION IS TO BE COMPLETED AND SIGNED BY A
LICENSED MEDICAL PROFESSIONAL**

I last examined the individual listed above on the following date: _____

Height: _____ Weight: _____ Blood Pressure: _____

The individual is under the care of a physician for the following conditions:

Current treatment and/or medications at the time of this report includes:

Treatment and/or medications to be administered at camp or on tour:

Additional information for health care staff at camp or on tour:

I attest that the medical information provided on this form is substantively correct.

In my opinion, this individual is is not able to participate in an active camp or concert tour program.

Signature: _____

Date: _____

Printed Name: _____

Title: _____