CONTRA COSTA Children's Chorus
Celebrating musical excellence since 1984

EMERGENCY AND HEALTH INFORMATION

Current Level: ☐ **L1** ☐ **L2** ☐ **L3** ☐ **L4**

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: ___ Current Grade: ___ School: _____Sex: M/F Home phone (___)_____

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 #:*** **(_____)** _____

	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 . . .

Chorister's Name: _____

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 _____

_____ _____
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: 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: _____/_____/_____ _____ _____
Parent Name (print) **Parent Signature**