EMERGENCY CONTACT INFORMATION

Robbinsdale Armstrong High School Choirs

Medical Information and Treatment Release

All information supplied is confidential and will only be released to adults responsible for your child's safety.
Medical forms will be destroyed after the tour.

Student's Full Name _____ **Choir** _____

Street Address	**City**	**State**	**Zip**

Phone	**Date of Birth**	**Height**	**Weight**	

1 Does your child have any serious health problems, behavior disorders, sight, hearing, or mobility limitations? *If yes, please list and describe.* **YES** **NO**

_____

_____

2 Does your child have any dietary requirements? *If yes, please describe.* **YES** **NO**

_____

_____

3 Are all childhood immunizations current, including tetanus?
Date of last tetanus shot: _____ **YES** **NO**

4 Does your child take any prescribed medications? *If yes, please list all medications, including dosages, and state whether the student is able to self-administer them.* **YES** **NO**

_____

_____

_____

_____

5 Has your child had surgery or been hospitalized within the last two years? *Please give date, diagnosis and outcome of each illness, accident or injury.* **YES** **NO**

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_____

_____

6 Does your child suffer from any allergies? *Please describe. (ex, bees, nuts, seafood, etc.)* **YES** **NO**

_____

_____

_____

7 Has your child been treated for ADHD, ADD, eating disorder, or any other psychological conditions within the past two years? *Please describe.* **YES** **NO**

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EMERGENCY CONTACT INFORMATION

Parent/Guardian Name	Home Phone	Work/Cell Phone
Parent/Guardian Name	Home Phone	Work/Cell Phone
Other Emergency Contact	Home Phone	Work/Cell Phone
Family Physician	Phone	
Dentist	Phone	
Medical Insurance Plan	Policy Number	Primary Policy Holder

In the event that my child, named above, is injured during tour at which I am not present, and if medical attention is required, I hereby authorize the director or other person designated by team leadership to sign any necessary medical treatment release or forms on my behalf.

Parent/Guardian Signature	Print Name	Date

List ALL medications (RX and OTC) that will be carried during travel: