

**CHILDREN'S CHORUS OF GREATER DALLAS**  
HEALTH FORM (2018-2019 SEASON)

Child's full name \_\_\_\_\_

Date of Birth \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI)  
Age \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_/\_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_/\_\_\_\_\_

Father's Work Phone \_\_\_\_\_/\_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_/\_\_\_\_\_

Mother's Work Phone \_\_\_\_\_/\_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_/\_\_\_\_\_

Friend or Relative to call if unable to reach parent in emergency: \_\_\_\_\_

Home Phone \_\_\_\_\_/\_\_\_\_\_ Work Phone \_\_\_\_\_/\_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_/\_\_\_\_\_

Name of Member's Physician \_\_\_\_\_ Phone \_\_\_\_\_/\_\_\_\_\_

Date of last Physical \_\_\_\_\_ Date of last Tetanus or Booster Shot \_\_\_\_\_

Is Member covered by a Health Insurance Policy? YES \_\_\_\_\_ NO \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

If Member requires hospitalization, where would you prefer he or she be taken? \_\_\_\_\_

Health History

Allergies

Diseases

Ear Infections _____	Hay Fever _____	Measles _____
Rheumatic Fever _____	Asthma _____	German Measles _____
Convulsions _____	Insect Stings _____	Mumps _____
Epilepsy _____	Dogs/Cats _____	Chicken Pox _____
Heart Condition _____	Foods (specify below) _____	Other (specify below) _____
Diabetes _____	Penicillin _____	
Fainting Spells _____	Other Drugs (specify below) _____	
Motion Sickness _____	Other (specify below) _____	
Wears Glasses/Contacts _____		

Describe any learning problems or disabilities \_\_\_\_\_

Describe any recent serious illnesses or operations \_\_\_\_\_

List medications currently being taken on a regular basis \_\_\_\_\_

**In Case of an Emergency, I give my permission to adult persons representing the Children's Chorus of Greater Dallas to obtain and agree to emergency medical treatment for my child, to hospitalize him/her if necessary, and to agree to surgical treatment to save my child's life, if, after diligent effort, a parent/legal guardian of the child cannot be located and medical exigencies require that a decision be made. It is understood that every effort will be made to reach the persons named on this form.**

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_