



**EMERGENCY AND HEALTH INFORMATION**

**Current Level:**  MG  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 #:** (\_\_\_\_) \_\_\_\_\_

	<b>Parent #1 /Guardian</b> (if Guardian, please state relationship to child)	<b>Parent #2 /Guardian</b> (if Guardian, please state relationship to child)
<b>Full Name</b>		
<b>Street Address</b>		
<b>City &amp; Zip Code</b>		
<b>Employer</b>		
<b>Job Title/Occupation</b>		
<b>Day/Business Phone</b>		
<b>Evening Phone</b>		
<b>Cell Phone</b>		
<b>Email</b>		

**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 . . .*

