Participant Information & Medical Form

PARTICIPANT INFORMATION

Name ______________________________________ Birthdate ________/______/______Current Age_______
Email or Parent email (if participant is a minor) ____
Address: Street ____
City ____ State __________ Zip ______________
Phone (______) ______-________ (Cell/Home) Phone (______) ______-________ (Cell/Home)
School (Full Name) ____ Grade _____________
Music Teacher's Name ____
Church (Full Name) ____
Church Address: Street ____
City ____ State __________ Zip _______________

PARENT/GUARDIAN INFORMATION (for minor participants) ***please list primary parent/guardian first***

Name of Parent/Guardian ____________________________Relationship to participant__________________
HCPAC Clearances on file? (circle) YES NO Are you willing to apply for these? (circle) YES NO
Address if different from above: Street____
City ____ State __________ Zip ______________
Phone (______) ______-________ (Cell/Home) Phone (______) ______-________ (Cell/Home)
Employer: ____ Occupation: ________________________________

Name of Parent/Guardian ____________________________Relationship to participant__________________
HCPAC Clearances on file? (circle) YES NO Are you willing to apply for these? (circle) YES NO
Address if different from above: Street____
City ____ State __________ Zip ______________
Phone (______) ______-________ (Cell/Home) Phone (______) ______-________ (Cell/Home)
Employer: ____ Occupation: ________________________________

Name of Parent/Guardian ____________________________Relationship to participant__________________
HCPAC Clearances on file? (circle) YES NO Are you willing to apply for these? (circle) YES NO
Address if different from above: Street____
City ____ State __________ Zip ______________
Phone (______) ______-________ (Cell/Home) Phone (______) ______-________ (Cell/Home)
Employer: ____ Occupation: ________________________________

Name of Parent/Guardian ____________________________Relationship to participant__________________
HCPAC Clearances on file? (circle) YES NO Are you willing to apply for these? (circle) YES NO
Address if different from above: Street____
City ____ State _________ Zip ______________
Phone (______) ______-________ (Cell/Home) Phone (______) ______-________ (Cell/Home)
Employer: ____ Occupation: ________________________________

Is there a child custody agreement in place? If YES, please describe: _____
_____

EMERGENCY CONTACT (if minor, choose an additional contact <u>if parent/guardians listed cannot be reached)</u>

Name _____ Phone (_____) _____-_____ (Cell/Home)
Relationship to Participant _____

PARTICIPANT MEDICAL INFORMATION

Current Height _____ Current Weight _____ Food/Environmental Allergies _____
List any Allergies to Medicine and what kind of reaction it causes: _____
_____
List all Medical, Psychiatric, and Behavioral Diagnoses: _____
_____
Explain above conditions (e.g., how well controlled, what is being done to treat, what we would need to tell EMTs in an emergency): _____-
_____
_____
Current Medications and what they are prescribed for: _____
_____
Is there any other information about the participant that we should know in seeking to best minister to his/her needs at HCPAC? _____
_____

Primary Physician _____ Office Phone _____
Health Insurance Carrier _____
ID/Policy Number _____ Group Number _____

The health history and other information requested above are complete and accurate to the best of my knowledge. The participant herein described has permission to engage in <u>all</u> prescribed activities except as noted above
I hereby grant authorization and consent for Harrisburg Christian Performing Arts Center (HCPAC) personnel to administer general first aid treatment for any minor injuries or illnesses experienced by myself/my minor child. If the injury or illness is life threatening or in need of emergency treatment and I am unable to authorize medical care, or, in the case of a minor, I, the parent/guardian cannot be reached, I grant authority to HCPAC personnel to seek medical attention on my behalf or that of my child listed above, to summon any and all professional emergency personnel to attend, transport, and treat myself/my minor child and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses resulting from such care.

Signature of Adult Participant or Parent/Guardian of Minor Participant

_____ Date _____

Harrisburg Christian Performing Arts Center
1000 S. Eisenhower Blvd. Middletown, PA 17025