



GREENSBORO YOUTH CHORUS

Medical Information

2010-2011

Circle Choir Beginner GCC CHL CTB

Contact Information

Name of Minor Child _____ Age _____

Address _____ Birth date _____

City, State & Zip _____ Phone (____) _____

Mother's/Guardian's Name _____

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Other Phone (____) _____

Father's/Guardian's Name _____

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Other Phone (____) _____

Emergency Contact Name _____ Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Other Phone (____) _____

Family Doctor/Pediatrician _____ Phone (____) _____

Travel Information (Circle Yes or No)

Traveled overnight before? Y or N Without Parents? Y or N Been very homesick? Y or N

Traveled by boat before? Y or N Traveled by airplane? Y or N Strong swimmer? Y or N

Medical Information

My child has experienced: fainting, dizziness, seizures, motion sickness, chronic problems, none
Other _____

Allergies or reactions to medications: _____

Any other allergies? (food, flowers, materials, dyes, stings, cigarette smoke, etc.): _____

Date of last Tetanus Shot: _____

Special medical needs: _____

Special dietary habits or needs: _____

Conditions requiring medications: _____

Medication	Dosage Amount	Dosage Time(s)	Comments/Instructions