

Summer Program Emergency Contact & Health Form

COMPLETED PROGRAM PAPERWORK IS DUE TWO (2) WEEKS PRIOR TO THE START OF THE PROGRAM. MAY 29TH, 2009

Emergency Contact Information Please do not list others participating in the same program as primary or backup emergency contacts. Be sure and list phone number where the person can be reached **during the program** (usually daytime phone or cell).

Faxes cannot be accepted. Copies may be downloaded from www.hawaiichildrenstheatre.com

NAME OF PARTICIPANT _____

Address _____ City _____ State _____ ZIP _____

Birthdate (Month / day / year) _____ Entering Grade in Fall 2007 _____

MOTHER: _____ Daytime Phone: _____ Cell: _____

FATHER: _____ Daytime Phone: _____ Cell: _____

ALTERNATE 1

EMERGENCY CONTACT: _____ Relationship: _____ Phone: _____

ALTERNATE 2

EMERGENCY CONTACT: _____ Relationship: _____ Phone: _____

MAY WE CONTACT YOU VIA EMAIL? Y / N Email address: _____

Medical Information

ALLERGIES & DIETARY RESTRICTIONS. Please list, describe reaction and management of the reaction as applicable.

MEDICATIONS. Please list all medications (including over-the-counter or nonprescription) taken regularly. Children are expected to bring whatever medical supplies or medications they will need each day and turn it in to staff, along with written instructions. Staff will be happy to remind them to take medication if we are notified in writing about their schedule.

MEDICATION: _____ Dosage: _____ Specific time taken: _____

Reason for taking: _____

MEDICATION: _____ Dosage: _____ Specific time taken: _____

Reason for taking: _____ see back

Do you want to be notified during the program session for minor injuries (e.g., scrape, non-allergic bee sting, bloody nose, sliver) that do not limit participation in the program? Y / N

Health Insurance Y / N Insurance Company _____ Policy/Group# _____

Participant ID # _____ Physician's name _____ Dr. Phone # _____

Are the child's immunizations current? Y / N / Date of last Tetanus shot _____

SPECIAL NEEDS. Are there any physical, mental, psychological or behavioral conditions requiring medication, treatment, or special restrictions or considerations while at the program of which we should be aware to ensure your child's fullest experience? Please describe, including any special accommodations necessary.

Are there any program activities from which the student should be exempted for health reasons?

PAST MEDICAL TREATMENT. Please list any major medical treatment, type and date:

If your child has a strong allergy to bee stings or other conditions that require the use of an epi-pen, the child is expected to have the required supplies with them at all times, and also they should know how to administer these injections themselves. Please indicate if this is the case:

Permission to Secure Treatment In the event of any emergency, I authorize Hawaii Children's Theatre to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for me or my minor child/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered. I understand that this authorization includes transporting my child by ambulance if necessary to the nearest medical treatment facility or hospital if I am unable to be reached first.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

PRINTED NAME _____