**ARCHBISHOP CURLEY HIGH SCHOOL CHOIR**
**2023-2024 Season**
**CHOIRCAMP MEDICAL FORM**

**Name:** _____
**(Last) (First) (Middle)**

**Address:** _____
**(Street) (City) (State) (Zip)**

**Name of Legal Guardian:** _____

**Address (if different from child's):** _____

**Guardian's phone:** **Daytime:** _____

**Nightime:** _____

**Cell:** _____

**Date of Last Tetanus Vaccine or Booster:** _____

**Allergies to Food or Drugs:** _____

**Chronic Illnesses/Conditions:** _____

_____

**Medications:** _____

_____

_____

**NOTE:** If your child will need medications during any choir trip/event/outing, a **written authorization from a physician** is needed permitting the chaperon staff to dispense the medication. This includes over-the-counter medicines such as Tylenol or cough medicine. **No** medicine will be administered to children without this authorization. If you think your child may need these medicines or occasionally needs inhalers fro asthma, please submit a **written authorization from a physician**.

**Recent Injuries/Operations:** _____

_____

**Physical Defects or Abnormalities:**_____

_____

_____

**Restriction on Athletics/Exercise:**_____

_____

_____

**Family Physician: Name:** _____

**Address:** _____

**Phone:** _____

**IN THE EVENT OF ILLNESS OR INJURY, EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT OR GUARDIAN HERE LISTED. SHOULD AN EMERGENCY OCCUR DURING ANY CHOIR EVENT/TRIP/OUTING, I HEREBY GRANT PERMISSION TO MICHAEL GAFFNEY OR TO ANY CHAPERON TO OBTAIN MEDICAL CARE FROM ANY LICENSED PHYSICIAN, HOSPITAL OR MEDICAL CLINIC. I HEREBY FURTHER DIRECT THAT A LEGIBLE PHOTOCOPY OF THIS FORM SHALL BE EFFECTIVE AS AN ORIGINAL.**

**I, AS LEGAL GUARDIAN OF THE MINOR CHILD ABOVE-NAMED, DO FURTHER HEREBY AGREE AND ACKNOWLEDGE THAT I, WITHOUT REQUEST OR SOLICITATION, WILL PROVIDE TO THE CHOIRMASTER AN UPDATED VERSION OF THIS MEDICAL FORM SHOULD ANY INFORMATION CONTAINED HEREIN REQUIRE ALTERATION, SUPPLEMENTATION OR REVISION.**

_____**(SEAL)** **DATE:**_____

**(Legal Guardian)**

**INSURANCE INFORMATION:**

**Name of Health Care Insurance Carrier:**_____

**Name of policy holder:**_____

**Policy#:**_____ **Group #:**_____

**Telephone number for approval procedures:(_____)**_____

**PLEASE STAPLE TO THIS FORM A LEGIBLE PHOTOCOPY OF YOUR CURRENT HEALTH CARE INSURANCE CARD.**