

**FIRST UNITED METHODIST CHURCH – DOWNERS GROVE, ILLINOIS
HIGH SCHOOL CHAPEL CHOIR TOUR
EMERGENCY INFORMATION**

NAME _____

ADDRESS _____

(include Town and Zip Code)

TELEPHONE NUMBER _____

MOTHER'S NAME (First & Last) _____ Work Phone _____

FATHER'S NAME (First & Last) _____ Work Phone _____

If parents will also be away from home while we are on Tour, please indicate below what address and telephone number they can be reached at:

Address _____

Phone Number _____

ALL CHOIR MEMBERS MUST SHOW PROOF OF INSURANCE COVERAGE:

Health Insurance Company _____

Policy and/or Group Number _____

Name of policy holder _____

Social Security No. _____

Billing Address _____

Telephone Number for claims _____

Name and telephone number of person that may be used in case of emergency only:

Name _____ Phone No. _____

Doctor's Name _____ Phone No. _____

Medical problems or allergies chaperones should be aware of: _____

(please include any pet or food allergies)

Date of last tetanus shot _____

Prescription medication needed to be taken:

Name _____

Dosage and times _____

Side Effects (If any) _____

(please see back side of this form for additional medication information)

Any over-the-counter drugs or nutritional supplements currently being taken _____

(PLEASE TURN OVER TO FINISH FORM)

Over-the-counter medication such as Advil, cough medicine and Imodium, for example, may be given to your child as needed, unless you specify otherwise.

- A. Do not give any over-the-counter medicines.
- B. OK to give over-the-counter medicines
- C. OK to give over-the-counter medicines except for the following: _____

Does your son/daughter wear contact lenses? Yes No

Are there any other problems your child may have that would be helpful for the chaperones to know?

As parent or legal guardian, I hereby give permission for my child to participate in the First United Methodist Church Chapel Choir Tour. I know that tour will take place during Spring Break of the year 2004.

I further understand that, in the event my child requires medical or dental treatment while engaged in these Tour activities, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the adult counselors acting on the behalf of the ministry with respect to this activity, as agent for me to consent to any X-ray examination; injections; anesthesia; medical, dental, or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are to be rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medication being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Signature _____
(Parent or Guardian)

Date _____