HARRISBURG CHRISTIAN PERFORMING ARTS CENTER'S INFORMATION SHEET

PLEASE **PRINT** ALL INFORMATION LEGIBLY

NAME ____ AGE____BIRTHDATE ___________

ADDRESS: ____
STREET CITY ZIP CODE

HOME PHONE ________________CELL PHONE _______________EMAIL _____________________

SCHOOL: _______________________________________ GRAD. YEAR_________ GRADE ________

CHURCH OF ATTENDANCE: ____

YOUTH PASTOR/DIRECTOR'S NAME____

ADDRESS____
STREET CITY ZiP CODE

FATHER'S NAME: ___________________________________WORK PHONE______________

ADDRESS:____
IF DIFFERENT FROM YOURS

MOTHER'S NAME____________________________________WORK PHONE _____________

ADDRESS:____
IF DIFFERENT FROM YOURS

LOCAL NEWSPAPERS (I.E., Guide, Intellegencer, Paxton Herald)____

I do____, do not ______ give my consent to HCPAC to use any pictures or videos taken of me for publicity, on the web page or on display in the Teen Center or for other sites.

LIST ALL MEDICATIONS YOU ARE TAKING ____

LIST ALL ALERGIES ____

NOTE ANY MEDICAL INFORMATION THAT MIGHT AFFECT MEDICAL TREATMENT AND/OR YOUR

INVOLVMENT IN ANY HCPAC PROGRAM____

EMERGENCY CONTACT ____

TELEPHONE NUMBER __________________________________ RELATIONSHIP________________

INSURANCE INFORMATION (COMPANY, POLICY NUMBER) ____

IN THE EVENT I AM UNABLE TO AUTHORIZE MEDICAL CARE OR, IF A MINOR, MY PARENT(S) OR GUARDIAN(S) CANNOT BE REACHED, I GRANT AUTHORIZATION TO HCPAC PERSONNEL TO SEEK MEDICAL ATTENTION ON MY BEHALF OR THAT OF MY CHILD, LISTED ABOVE, AND AUTHORIZE THE ATTENDING PHYSICIAN(S) TO ADMINISTER ANY MEDICAL TREATMENT OR TO ADMINISTER ANY SUCH ANESTHETICS AND TO PERFORM ANY SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREAMENT OF THE ABOVED NAMED PERSON.

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SIGNATURE - IF UNDER 18 MUST BE SIGNED BY PARENT(S) OR GUARDIAN(S) DATE