



817 Vine Street, Suite 204
Los Angeles, CA 90038
Ph: (323) 462-4311 Fx: (323) 462-4367
www.harmony-project.org

Emergency Information

(front and back)

Personal Information

Student's Name: _____ Age: _____ Birthday: _____

Street Address: _____ Home Number: _____

City: _____ Zip Code: _____ Pager/Mobile: _____

Mother's Name: _____ Home #: _____ Work #: _____

Father's Name: _____ Home #: _____ Work #: _____

Guardian's Name: _____ Home #: _____ Work #: _____

Medical Information

Emergency Contact: _____ Home #: _____ Work #: _____

Emergency Contact: _____ Home #: _____ Work #: _____

Participant's Medical Plan: _____ Insurance #: _____

Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Current Medical Problems and/or Allergies: _____

Current Medications and/or Special Needs: _____



Emergency Information (page 2)

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May your child be given aspirin or Tylenol if needed? Yes No Benadryl? Yes No

Has the child had any of the following?

Chicken pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colds	<input type="checkbox"/> Yes <input type="checkbox"/> No
Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
German measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach upset	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diphtheria	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nosebleed	<input type="checkbox"/> Yes <input type="checkbox"/> No

List **year** of last immunization or booster

Tetanus _____ Diphtheria _____ Whooping cough _____

Polio _____ Mumps _____ Measles _____

German measles _____

Medical Authorization

Should it be necessary for the student, parent(s), and/or guardian listed above to receive medical care while participating with The Harmony Project and/or any activities with which it is affiliated, I/we hereby give The Harmony Project personnel permission to use their judgment in obtaining that care. I/We also give permission to the physician selected by The Harmony Project personnel to render medical care that s/he deems necessary and appropriate. I/We understand that The Harmony Project has no insurance covering medical or hospital costs incurred by any participant and, therefore, any cost incurred for such treatment will be entirely my/our responsibility.

Parent or Guardian Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____