



WASHINGTON WORKSHOPS FOUNDATION  
**CHAPERONE  
 INFORMATION FORM**

**THIS FORM IS  
 CONFIDENTIAL**

THIS CHAPERONE INFORMATION FORM SHOULD BE FILLED OUT, SIGNED, AND RETURNED TO THE WASHINGTON WORKSHOPS OFFICE WITH YOUR FINAL PAYMENT OR AT YOUR EARLIEST CONVENIENCE.

Session _____	Name _____ Last First MI
_____	SSN _____ Date of Birth _____

Gender: Male\_\_\_\_ Female\_\_\_\_ Circle All That Apply: Teacher Parent Principal Other Email: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 zip \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Childs Name \_\_\_\_\_

**INSURANCE:**

Each participant should determine whether his/her medical insurance coverage includes coverage for medical problems that occur away from home. If you have such coverage, please state as follows:

Name of Insurance Company: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_

**NAME AND ADDRESS OF FAMILY PHYSICIAN:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_

**PARTICIPANT DRUG SENSITIVITIES OR PHYSICAL LIMITATIONS:**

The participant is known to react unfavorably, is allergic to, or requires special treatment:

Food or Drugs: \_\_\_\_\_  
 Medicines currently being taken: \_\_\_\_\_  
 Physical Limitations: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact Name \_\_\_\_\_ Office Phone \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Alternate Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

It is the understanding of this participant that in the event a medical emergency should arise requiring medical care to be administered immediately, the Participant authorizes that such emergency medical treatment shall be given and consent to such treatment at a hospital or other health care dispenser, or initially by seminar staff, if necessary.

The undersigned have read the above and declare and affirm that they consent to the contents herein stated.

\_\_\_\_\_  
 Chaperones signature

\_\_\_\_\_  
 Date