Crowning Achievements
A Special Needs Pageant

Health Information Form

Name: _____ Birthdate: _____

Sex: M F

Address: _____

_____

Phone Number: _____

Email: _____

****

Parent/Guardian Name(s): _____

Parent/Guardian Address(s): _____ _____

_____ _____

Parent/Guardian Phone Number(s): _____ _____

Email(s): _____ _____

Doctor/Clinic: _____

Clinic Address: _____

_____

Clinic Phone Number: _____

Insurance Provider: _____

Policy Number: _____

Policy Holder: _____

Insurance Phone Number: _____

Insurance Address: _____

Crowning Achievements, Inc.
1308 7th Street
Hudson, Wi 54016
715-381-1896 or 612-850-2298
crowning.achievements@hotmail.com
www.crowningachievements.org

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A Special Needs Pageant

Please list the participant's diagnosis so we can provide the best service for the participant:

_____

How can we best help your participant if they are agitated or upset/adaptations, etc?

_____

What are some interests that your participant likes to talk about or participate in?

_____

Are there any other special care instructions that would be helpful and/or necessary for us to provide the best service for the participant:

_____

_____

Please list any allergies, special diet, etc. that we should be aware of:

_____

Participant Living Situation (with family, group home, independent, etc)?

_____

In case of emergency, and we are unable to contact you, please list individuals you would like us to contact.

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Please sign below to consent for us to use the information listed above.

Participant: _____ Date: _____

Guardian (if applicable): _____ Date: _____

**** This form must be returned to Crowning Achievements before attending an event.**

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