



# Project Contemporary Competitiveness, Inc. PARENT/GUARDIAN QUESTIONNAIRE

Student Name (Last, First, M.I. & Optional Nickname/preferred name) \_\_\_\_\_

Account Number \_\_\_\_\_ Parent email \_\_\_\_\_

**PLEASE PRINT CLEARLY**

Street \_\_\_\_\_ Phone \_\_\_\_\_ 8

Town \_\_\_\_\_ Zip \_\_\_\_\_

School Currently Attending \_\_\_\_\_ Grade \_\_\_\_\_

**IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT:**

**Parent/Guardian #1 (print)**

**Parent/Guardian #2 (print)**

Name \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

Night(\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

\_\_\_\_\_

**FAMILY PHYSICIAN** \_\_\_\_\_ **Phone** (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT PERSON:** Record the name of a person who would assume temporary care of your child in the event you cannot be reached:

**Name** \_\_\_\_\_ **Phone** (\_\_\_\_) \_\_\_\_\_

**STUDENT INFORMATION**

Does the student have any health problems? No \_\_\_ Yes \_\_\_

If yes, please explain \_\_\_\_\_

Does the student have any behavioral or psychological problems? No \_\_\_ Yes \_\_\_

If yes, please explain \_\_\_\_\_

Will the student require prescription medication while at PCC? No \_\_\_ Yes \_\_\_

Name of Medication(s)? \_\_\_\_\_

Is the student currently restricted in any physical activities? No \_\_\_ Yes \_\_\_

If yes, please explain \_\_\_\_\_

Is the student allergic to any food, medication or insect bites? No \_\_\_ Yes \_\_\_

If yes, please explain \_\_\_\_\_

**MY/OUR SIGNATURE(S)**

1. Authorizes the school to release school records (if needed) to the Advanced Studies Program (ASP).
2. Authorizes the ASP to contact our family physician listed above if they are unable to reach me/us.
3. Certifies my child and I have read, accept, and agree to abide by the Code of Conduct. (Pccasp.org)
4. Indicates that I/we assume all responsibility and will make restitution for any damages to college property which may be directly attributed to my child.
5. Authorizes a press/website release for PCC/ASP picture and name.

**A Deposit of Two Hundred-Fifty Dollars (\$250.00) must be submitted with this questionnaire to register your child if you have not done so already.**

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name (s)** \_\_\_\_\_

N.B. Please be advised that any medical information you provide will be disclosed only to those people who have a need to know in order to provide for the safety of your child. You have the right to request restrictions on the disclosure of your child's medical information. While we will consider your request, we are not required to accept it.