Project Contemporary Competitiveness, Inc.
Advanced Studies Program
PARENTAL QUESTIONNAIRE

_____ **Male ( ) Female ( )**
Student Name (Last, First, Middle Initial)

Account Number _____

Street_____ Phone_____

Town_____ Zip_____

School Currently Attending_____ Grade ___

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT:

MOTHER (print)	**FATHER/OTHER (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 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.
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.

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.