

EMERGENCY MEDICAL INFORMATION AND RELEASE

****PLEASE FILL OUT COMPLETELY****

School Year _____

Student Name _____ Home Phone _____

Address _____

Social Security Number _____ Birthdate _____ Birthplace _____

Parent's (Guardian's) Name(s) _____

Father's Employer Name and Address _____

Father's Business Phone _____ Father's Cell Phone _____

Mother's Employer Name and Address _____

Mother's Business Phone _____ Mother's Cell Phone _____

Insurance Co _____ Phone _____ Policy No _____

Two Persons you recommend we call in event you cannot be reached:

_____ Phone _____

_____ Phone _____

Preference of Physicians:

1. _____ Phone _____ Address _____

2. _____ Phone _____ Address _____

If neither physician is available, do we have your permission
to take your student to a hospital or available physician? _____

Preference of Hospital _____

Medical history and physical limitations or problems that should be known by the Band Staff: _____

Date of last Tetanus shot _____ Drug Allergies _____

If I cannot be reached in case of accident or illness requiring emergency medical treatment, I do hereby consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be rendered.

Date _____ Parent or Guardian Signature _____

Date _____ Parent or Guardian Signature _____

PLEASE NOTE: ALL STUDENTS PARTICIPATING IN SCHOOL ACTIVITIES WHERE TRAVEL IS REQUIRED MUST HAVE INSURANCE COVERAGE.