

Student Medical Emergency & Contact Information

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Student ID #: _____ Grade: _____

Is the student allergic to any medication and/or food? _____

If so, which? _____

In case of sickness, may this student take one dose of: Aspirin? ____ Ibuprofen? ____ Imodium AD? ____, Pepto Bismol? ____

Does this student wear contact lenses? _____ Prescription glasses? _____

Does this student suffer from: Hay Fever _____ Allergies _____ Asthma _____

Does this student take any medication? _____

If so, which? _____

Any other health history that may assist the person in charge should this student become ill?

First Contact in Case of Emergency:

Parent/s or Guardian/s Name/s: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ (Home) Phone 2: _____ (Work)

Phone 3: _____ (_____) Phone 4: _____ (_____) _____ (_____)

Family Physician

Name: _____ Phone: _____ Other Phone: _____

Other Emergency Contact(s) - Optional

Name / Relationship: _____ Phone: _____

Name / Relationship: _____ Phone: _____

Name / Relationship: _____ Phone: _____

WE DO [] WE DO NOT [] HAVE HEALTH OR ACCIDENT INSURANCE

Insurance Company Name: _____

Group Number: _____ Policy Number of Group: _____

This Form has been filled out to the best of my knowledge. I hereby authorize medical treatment of _____ in the event of any emergency, illness or accident. I accept all responsibility and liability for any occurrence during this student's participation with the Colorguard. *I further agree to be available during Colorguard trips at one of the numbers listed above or ensure that an alternate means of contact is written on this form BEFORE any trip.*

Signature of Parent or Guardian

Signature of Parent or Guardian

Today's Date