EMERGENCY MEDICAL FORM

Student Name:____
(Print Last/First)

Performing Unit:______________________ Date of Birth:________________________
(A Guard / World Guard)

CONTACT INFORMATION

Parent 1 *(Guardian 1)* Name ______ Home Number ______ Cell/Work Number ______

Parent 2 *(Guardian 2)* Name ______ Home Number ______ Cell/Work Number ______

Emergency Contact *(If Parent is not available)* ______ Home Number ______ Cell/Work Number ______

Home Address ______ City ______ State ______ Zip ______

MEDICAL/INSURANCE INFORMATION

Physician's Name ______ Phone Number ______ Address ______

Please list any known Allergies, Medical Condition, and Medication (including Dosage):

HEALTH/ACCIDENT INSURANCE

_______ ***My child IS COVERED by twenty-four (24) hour insurance:***

Insurance Company: ____________________________________ **Policy Number:** ____________________

_______ ***My child does NOT HAVE insurance, however, I will pay any and all medical bills for the emergency care of my child.***

PERMISSION FOR MEDICAL TREATMENT

I, the undersigned, being the parent/legal guardian of the aforementioned student, hereby authorize any necessary medical treatment, to include the administration of any medications, prescribed by a doctor in attendance of this student while onapproved field trips. I also guarantee payment of any c harges incurred during this medical treatment.

____ ______________

Parent/Guardian Signature ***Date***