ARMADA MUSIC DEPARTMENT
EMERGENCY MEDICAL INFORMATION SHEET

Please complete and return this form to the teacher by the requested date.
PLEASE PRINT

STUDENT NAME ______________________________

GRADE __________ DATE OF BIRTH ______________ AGE ______________

ADDRESS ______________________________
STREET CITY ZIP

HOME PHONE ______________________

FATHER/GUARDIAN: ______________________ RESIDES: YES NO

WORK PHONE: ______________________ CELL/PAGER ______________

MOTHER/GUARDIAN: ______________________ RESIDES: YES NO

WORK PHONE: ______________ CELL/PAGER ______________________

PHYSICIAN: ______________________ PHONE ______________

MEDICAL INSURANCE INFORMATION: **(REQUIRED)**

POLICY NAME ______________________________

POLICY HOLDER ______________________________

CONTRACT / GROUP NUMBER ______________________________

HOSPITAL PREFERENCE ______________________________

LIST ALL MEDICATION CURRENTLY BEING USED: ______________________________

____

ALLERGIES / MEDICAL CONDITIONS ______________________________

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IN THE EVENT OF AN EMERGENCY PLEASE LIST CONTACT INFORMATION.
(CONTACT WILL BE MADE IN ORDER INDICATED):

NAME: RELATIONSHIP: PHONE:

#1. ______________________________

#2. ______________________________

#3. ______________________________

I ______________________(parent/guardian) recognize that as a result of participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

______________________________ ______________________
SIGNATURE (PARENT/GUARDIAN) DATE