

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 _____

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

NAME:	RELATIONSHIP:	PHONE:
#1. _____	_____	_____

#2. _____	_____	_____
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#3. _____	_____	_____
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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