

EMERGENCY MEDICAL FORM



Student Name: _____
(Print Last/First)

Performing Unit: _____
(A Guard / World Guard)

Date of Birth: _____

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 on approved field trips. I also guarantee payment of any charges incurred during this medical treatment.

Parent/Guardian Signature _____

Date _____