EMERGENCY MEDICAL FORM

STONEMAN DOUGLAS COLOR GUARD

WINTER 2026

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***