

# Westmoore Band Emergency Medical Information

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone # \_\_\_\_\_

In case of emergency, illness or accident to the above named child, the activity sponsor(s) are authorized to proceed as indicated.

Father/Guardian's Name \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Family Physician \_\_\_\_\_

Phone \_\_\_\_\_

*Please list any physical disability and/or drugs to which your child may be sensitive.*

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*List two (2) persons other than parents to call in case of emergency.*

Name \_\_\_\_\_

Work phone \_\_\_\_\_

Name \_\_\_\_\_

Work phone \_\_\_\_\_

## *Authorization for Medical Care of a Minor*

\_\_\_\_\_, the undersigned parent or person having legal guardianship of  
(Print name of Parent/Guardian)

\_\_\_\_\_ do hereby authorize the activity sponsor(s) to consent to an  
(Print name of Student)

x-ray, examination, anesthetic, medical surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist. In giving consent, I recognize and understand that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me. Such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures if any, or to evaluate the risk attendant upon each and the risks attendant to foregoing to all treatment. In such situations, I authorize a physician, surgeon or dentist to exercise his/her professional judgment and assess the risks incident to and choose the right treatment from any available alternatives and to render such care and perform such treatment as he/she in his/her professional judgment determines to be necessary for the health or safety of the above named minor.

\_\_\_\_\_  
(Signature of parent or person having legal custody or legal guardian)

\_\_\_\_\_  
(Date)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Country \_\_\_\_\_

(Complete front and back of sheet)

(Revised: 8/00)

# Westmoore Band Emergency Medical Information

Minor's Allergies \_\_\_\_\_

Medicine Minor is Taking \_\_\_\_\_

*List all medication(s) minor will take on trips. (Please include over the counter medications).*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Minor's last Tetanus Shot \_\_\_\_\_

Minor's Medical History \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insurance Provider/Company \_\_\_\_\_

Policy # \_\_\_\_\_