

2011-2012 Wadsworth High School Band  
Emergency Medical Form

Student's Grade \_\_\_\_\_

Student's Name \_\_\_\_\_ Address \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Father's Name \_\_\_\_\_ Address \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Address \_\_\_\_\_

Primary Medical Insurance Co. \_\_\_\_\_ Policy/Group Number \_\_\_\_\_ List Employer and indicate who is the insurance holder \_\_\_\_\_

With whom does the child reside?  Father  Mother  Both  Other (list names) \_\_\_\_\_

Who has custody of the child?  Father  Mother  Both  Other (list names) \_\_\_\_\_

STUDENT'S SOCIAL SECURITY # \_\_\_\_\_ Date of birth: \_\_\_\_\_

Those designated below, other than parents, are authorized to pick up my child from school in an emergency (listed in order of preference):

- 1. Person's Name: \_\_\_\_\_ Relationship to child \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone w/ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_
- 2. Person's Name: \_\_\_\_\_ Relationship to child \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone w/ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Use back for others

**MEDICAL INFORMATION**

List Student's known allergies and medical conditions: \_\_\_\_\_

Medications being taken (dosage): \_\_\_\_\_

Known Drug Allergies: \_\_\_\_\_ Asthma Inhaler name: \_\_\_\_\_

Does student carry an EPI pen? \_\_\_\_\_ Does the student carry a glucose pen? \_\_\_\_\_

Preferred Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital (or closest): \_\_\_\_\_

**PARENTAL CONSENT:** In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF OHIO  
COUNTY OF MEDINA

Before me, a notary Public in and for the said County and State, personally, appeared \_\_\_\_\_ who acknowledged before me that he/she did sign the foregoing instrument and that the same in his free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at \_\_\_\_\_, Ohio \_\_\_\_\_ day of \_\_\_\_\_, 2011.

\_\_\_\_\_  
Notary Signature