WASECA HIGH SCHOOL BAND 2020
Emergency Information
Please Print

Student's Name: _____
(Last, First, Middle)
Home Address: _____
(Street, City, Zip)
Birthdate: _____ Grade: _____ Sex: M / F

Mother's Name: _____ Address: _____

Phone #'s- Home: _____Work: _____Cell: _____

Father's Name: _____Address: _____

Phone #'s- Home: _____Work: _____Cell: _____

IN CASE OF EMERGENCY, AND YOUR PARENTS CANNOT BE REACHED, THE FOLLOWING SHOULD BE CONTACTED:

Contact #1: _____ Phone #: _____

Contact #2: _____ Phone #: _____

Family Doctor: _____ Phone #: _____

Family Dentist: _____ Phone #: _____

Does the student wear prescription glasses or contacts? Yes _____ No _____

Does the student have motion sickness tendencies? Yes_____ No_____

ALL MEDICAL INFORMATION IS KEPT CONFIDENTIAL

Please list **any/all** medical conditions that emergency personnel should be aware of:
(i.e. allergies, drug allergies, asthma, diabetic, special health needs, etc.) □ **NONE**

_____

_____

_____

Please list **all** medications taken on a regular basis (Please list conditions for which they are taken, dosage and frequency. Please include inhalers.) □ **NONE**

_____

_____ **OVER ➔**

The following items are items that we will have available in our travel health kit. **Please review this list and circle any items that you would <u>NOT</u> like your child to receive**:

TYLENOL	BENADRYL	COUGH DROPS
IBUPROFEN	ANTIBIOTIC OINTMENT	TUMS
SUDAFED	ROBITUSSIN DM	MOTION SICKNESS MEDS

Insurance Information:

Primary Carrier of Insurance: Mother _____ Father _____

Name: _____Birthdate:_____
(Last, First, Middle)

Place of employment: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Insurance Policy #: _____ Insurance Group #: _____

Other pertinent insurance information:

_____

_____

If impossible to contact parents or any of the contacts listed on the reverse side, I give permission and consent to the Waseca High School Band Director(s) or Chaperone(s) to call the rescue squad, arrange for immediate medical treatment by licensed physician and/or other medical personnel, and for such physician or other medical personnel to apply such emergency techniques which in their judgment they deem necessary to treat any injury/illness sustained by my child. I further authorize any and all emergency medical treatment as is necessary for the health and welfare of my child.

_____ I agree to the above statement

_____ I disagree to the above statement (A meeting with the director will need to happen prior to the trip to discuss the action plan in the event an emergency occurs).

_____ _____
Parent or Legal Guardian Signature Date

I do hereby agree to hold harmless and indemnify the Waseca School District, directors, and chaperones and its members from all claims, demands, damages or causes of action or injuries, including reasonable attorney's fees and costs in the defense thereof, arising out of the physician and/or other medical personnel.

_____ _____

Parent or Legal Guardian Signature Date

I have filled out and checked the above information to insure accuracy in the event of an emergency or other instance. I understand that the above information will be kept confidential and only used if needed.

_____ _____

Parent or Legal Guardian Signature Date