

Name \_\_\_\_\_

Section \_\_\_\_\_

### WEBSTER MARCHING BAND EMERGENCY MEDICAL FORM

- this form is required to be filled out by parent or guardian and returned as directed by the deadline.

School \_\_\_\_\_ Activity \_\_2008 MB Season\_\_ Band Director \_\_Richard Fischette\_\_ Date \_\_\_\_\_

Student \_\_\_\_\_ Birthdate \_\_/\_\_/\_\_ Sex (M) (F) Grade \_\_\_\_ Phone (H) \_\_\_\_\_

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Father/guardian \_\_\_\_\_ Address \_\_\_\_\_ Phone #'s [W] \_\_\_\_\_ [C] \_\_\_\_\_  
[H] \_\_\_\_\_

Mother/guardian \_\_\_\_\_ Address \_\_\_\_\_ Phone #'s [W] \_\_\_\_\_ [C] \_\_\_\_\_  
[H] \_\_\_\_\_

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If parent or legal guardian cannot be contacted in an emergency, the school is authorized to call:

Insurance Provider \_\_\_\_\_ Subscriber Name \_\_\_\_\_ Policy # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Other \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to child \_\_\_\_\_

If none of the above named can be reached, please call an available licensed physician or dentist. You may take my child to the nearest Emergency First Aid Station by ambulance, if necessary. This authorizes treatment of my child by a physician/hospital in case of an emergency.

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Health and Medical Info: Please circle YES or NO. If YES, please explain. Date of Last Tetanus Shot \_\_\_\_\_

Allergies YES NO Seizures YES NO Asthma YES NO  
(food,plants,insect bites,meds,etc)  
Diabetes YES NO Wear Contact Lenses YES NO Other (specify) \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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Do you have any physical disabilities or conditions which may limit your participation in this activity? YES NO

If YES, please explain: \_\_\_\_\_

Are there any medications (prescribed or over-the-counter) that you will need to take while on this field trip? YES NO  
If YES, a physician's written order and a self-medication order MUST BE ATTACHED for any prescription or over-the-counter medications.  
I give my permission to the Band Director/Medic to discuss health concerns/medication with the prescribing physician.

I certify that the above information is true and accurate and I understand that it will be relied upon by the Webster Central School District

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date