



# Student Emergency Information Form Winter 2011-2012

## Permission for Emergency Treatment

Please return this form to any SCACMB Director or mail to:  
St. Cloud All-City Marching Band  
PO Box 7762  
St. Cloud, MN 56302-7762

(PLEASE PRINT AND USE BLACK OR BLUE INK ONLY)

Student Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Year of Graduation \_\_\_\_\_ School Attending: \_\_\_\_\_

Student's Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Work Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Work Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_

Person to contact in case parent cannot be reached \_\_\_\_\_ Phone \_\_\_\_\_

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Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Name of Health Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Does your insurance company have any special requirements you want us to know about? Yes: \_\_\_\_\_ No: \_\_\_\_\_

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

Is the student on any medication (continuous or intermittent)? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please explain. \_\_\_\_\_

(PLEASE CONTINUE ON BACK SIDE)

STUDENT NAME: \_\_\_\_\_

Do any of the following conditions pertain to your student?

Diabetic Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Asthmatic Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Fainting Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Hyperventilating Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Sleepwalking Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Diet Restrictions Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Does the student have any medication allergies or food allergies?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Date of Last Tetanus Immunization: \_\_\_\_\_

Does the student wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there any past medical history we need to be aware of (surgical, hospitalization, serious chronic illness)?

Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

**PERMISSION FOR MEDICAL TREATMENT**

I give permission for the Band Chaperones or Band Directors to authorize necessary medical treatment for the above named student. I understand that, should a medical emergency arise, every effort will be made to contact me before such treatment is given.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_