BIG MO

MEDICAL FORM

• To be completed by parent or guardian or 18-year-old.

STUDENT'S NAME:	LAST FIRST		SEX	GRADE	DATE OF BIRTH	AGE
STUDENT'S ADDRESS:	STREET		TY		ZIP	
FATHER'S / GUARDIAN'S NAME		WORK PHONE	MOTHER'S / GUARDIAN'S NAME		WORK PHONE	
FAMILY DOCTOR			OFFICE PHONE		HOME (After hours) PHONE	

INSURANCE STATEMENT & MEDICAL HISTORY

Our son/daughter will comply with the specific insurance regulations of the school district. Please provide a copy of the students medical insurance card(s).

• Family Insurance Co. _____

• Contract #_____

• Signature of Parent or Guardian or 18-Year-Old: _____

HISTORY	YES	NO	HISTORY	YES	NO	HISTORY	YES	NO
Have you ever had:			**Have you ever had:**			**Do you now have:**		
ADD / ADHD			Hemophilia			Autism		
Allergies			High Blood Pressure			Blackouts		
Asthma			Other:			Convulsions		
Autism						Diabetes		
Blackouts			**Do you now have:**			Heart Disease		
Convulsions			ADD / ADHD			Hemophilia		
Diabetes			Allergies			High Blood Pressure		
Heart Disease			Asthma			Other:		

Any and all explanations:

MEDICAL TREATMENT CONSENT

To be completed by Parent or Guardian or 18-year-old

I, _____ , an 18-year-old, or the parent or guardian of _____ , recognize that as a result of robotics participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

SIGNATURE OF PARENT OR GUARDIAN OR 18-YEAR-OLD DATE

X

EMERGENCY INFORMATION - To be completed by Parent or Guardian or 18 yr. old

Student's Name:		Grade:
IN EMERGENCY	1)	Phone:
CONTACT: or	2)	Phone:

My Family Doctor Is: _____. Please detail any special medical information

(allergies, known drug reactions, current prescribed medications)