Revised: 8/26/09

Charlottesville/Albemarle Robotics

Emergency Medical Information

Student's First/Last Names: _____ DOB: _____ SS# _____

Parent/Legal Guardian: _____

Address: _____ City/State: _____

Home Phone: _____ Work or Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Address: _____ City/State: _____

Home Phone: _____ Work or Cell Phone: _____

Insurance or Medicaid: _____ Policy Number: _____

Current Prescription and over-the-counter Medications: _____

_____

Medication/Food Allergies: _____

_____

History of Substance Abuse: _____

_____

Significant Medical Problem(s): _____

_____

Significant Communication Problem(s): _____

_____

Physician Name: _____ Phone: _____

Address: _____ City/State: _____

In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give Charlottesville Albemarle Robotics permission to act on my behalf in seeking emergency treatment for my child in the event the representatives of the organization deem such treatment necessary. I give permissioin to those administering emergency medical treatment to do so, using those measures deemed necessary. I absolve Charlottesville Albemarle Robotics and their designed representatives from liability in acting on my behalf.

_____ _____

Parent/Guardian Date