

**CHARLOTTESVILLE ALBEMARLE ROBOTICS**  
**FIRST Team 619 Cavalier Robotics**  
**EMERGENCY MEDICAL INFORMATION 2018-2019**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Current Prescription and over-the-counter Medications:

\_\_\_\_\_

Medication/Food Allergies:

\_\_\_\_\_

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 permission to those administering emergency medical treatment to do so, using those measures deemed necessary. I absolve Charlottesville Albemarle Robotics, the University of Virginia, and all of their designated representatives from liability regarding the injury and in acting on my behalf.

\_\_\_\_\_  
**Parent/Guardian Name (print)**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**