

M-A Robotics Team Contact and Medical Information Form

Parents and students, the robotics team needs to be able to contact you in case of an emergency during a team meeting or build session, and for team communications and event coordination. Remember that safety is our top priority and that this information is purely a precautionary measure. All medical information provided will be kept confidential. The student/parent contact information is compiled into a password protected roster on the website, and phone numbers will be included in a wallet-sized contact card distributed to all team members. Please check here if you **do not** want your contact info included: _____

Student: Name: _____
DOB: _____ Height: _____ Weight: _____
Address _____
Email: _____
Home phone: _____
Cell phone: _____

Contact in case of emergency:

Parent/Guardian 1: Name: _____
Address _____
Email: _____
Home phone: _____
Work phone: _____
Cell phone: _____

Parent/Guardian 2: Name: _____
Address _____
Email: _____
Home phone: _____
Work phone: _____
Cell phone: _____

Alternate Contact Name: _____ Phone: _____

Name of Doctor: _____ Phone: _____

Doctor's Address: _____

Name of Health Insurance Co.: _____ Policy No. _____

Any other pertinent information on card: _____

List any regularly taken medication: _____

List any medicine allergies: _____

Have you ever been treated for (if currently being treated, please indicate):

Nervousness	_____	Ulcers	_____
High blood pressure	_____	Heart condition	_____
Any mental disorder	_____	Diabetes	_____
Severe/frequent headaches	_____	Rheumatic Fever	_____
Convulsions/Epilepsy	_____	Allergic reaction to medication	_____
Asthma	_____	Cancer of tumor	_____
Fainting spells	_____	Other allergies of illnesses	_____

Do you have any other physical limitations?

Give details of 'yes' answers to any of the questions above. Give dates of treatment and names of doctors, hospitals, clinics. Continue on reverse side if necessary. _____

Please read carefully and sign below.

I hereby certify that the information given above is correct. In case of medical emergency, I understand that every effort will be made to contact the person(s) designated above. In the event that the aforementioned contact person(s) cannot be reached, or time does not permit, I hereby give permission to a licensed physician to provide proper treatment to my child, including hospitalization, immunization, anesthesia, or surgery.

Parent Signature: _____ Date: _____