

2017-2018
SPEECH
&
DEBATE

MEDICAL
FORM PACKET

***Must be submitted in order to participate
as a member of Speech & Debate***

2017-2018 Speech & Debate

MEDICAL & CONTACT INFORMATION

Student Name: _____ Grade: _____

Please complete, sign and submit these forms to begin active participation as a member of Speech & Debate.

HOME ADDRESS _____ D.O.B. _____
_____ AGE _____

MEDICAL INFORMATION

CURRENT MEDICATION & DOSAGE
(special instructions?) _____

ALLERGIES
(medicines, foods,
environment, products, etc.) _____

CHRONIC MEDICAL SITUATIONS
(special instructions?) _____

SIGNIFICANT MEDICAL HISTORY
Please include dates/years.
(operations, illnesses
broken bones, etc.) _____

FAMILY PHYSICIAN _____
Hospital Affiliation _____

DATE OF LAST PHYSICAL EXAMINATION _____

DATE OF LAST TETANUS SHOT _____

DOES THE STUDENT WEAR CONTACT LENSES? Yes No

continued on the next page

2017-2018 Speech & Debate

EMERGENCY CONTACT INFORMATION: PHONE

Student Name: _____ Grade: _____

Parent 1 Name: _____

Preferred Phone Contact: (Please list at least one and as many others as you wish for normal and emergency phone contact.)

Cell: _____ Work: _____ Home: _____

Parent 2 Name: _____

Preferred Phone Contact: (Please list at least one and as many others as you wish for normal and emergency phone contact.)

Cell: _____ Work: _____ Home: _____

CONTACT INFORMATION: EMAIL

PLEASE PRINT NEATLY

Preferred Contact Email (Parent 1): (Please list as many as you wish)

Preferred Contact Email (Parent 2): (Please list as many as you wish)

CONTACT INFORMATION: EMERGENCY

In case of an emergency of ANY kind, if parents are not able to be contacted for whatever reason, knowing how to contact others who could assist (older siblings, step-parents, relatives, neighbors or friends) could be essential in order to provide due care to a student cast member. All information is kept confidential

NAME

PHONE NUMBER

EMERGENCY MEDICAL RELEASE

I verify that the information above is accurate. I give my consent for emergency medical treatment to be given to my child by authorized medical personnel, including by doctors in a hospital setting if needed.

Parent Signature

Date

2017-2018 Speech & Debate INSURANCE VERIFICATION

Student Name: _____ Grade: _____

Please complete, sign and submit these forms.

The West Allegheny School District has provided Accident Insurance Coverage for student participants in extra-curricular activities with coverage for the 2017-2018 school year beginning Monday, August 21, 2017.

Family information with regard to student health insurance and hospitalization policies is also essential and must be on file. Please check the appropriate blank, complete the information requested and sign below. *All information remains confidential.*

_____ My child is covered with health insurance/hospitalization under a policy as follows:

COMPANY/HMO, ETC.: _____

POLICY NUMBER: _____

GROUP NUMBER: _____

Please state the NAME and ADDRESS of the party that provides this insurance:

Are there any special instructions with insurance policies or HMO? (I.e. Own doctor notified first, etc.)

_____ My child will be covered by insurance purchased through West Allegheny High School for 2017-2018.

_____ My child is covered by public assistance.

_____ My child has no insurance/hospitalization coverage.

Parent Signature

Date