

**THCBC EMERGENCY / MEDICAL INFORMATION**

Student Name: \_\_\_\_\_

Age \_\_\_\_\_ Grade (2017-18) \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_

Dad's Name: \_\_\_\_\_ Dad (H): \_\_\_\_\_ Dad (C) \_\_\_\_\_ Dad (W) \_\_\_\_\_

Mom's Name: \_\_\_\_\_ Mom (H): \_\_\_\_\_ Mom (C) \_\_\_\_\_ Mom (W) \_\_\_\_\_

If parents cannot be reached: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

1. My Child has had the following: (Please check)

- |                                      |  |  |   |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Serious Injury         |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Surgery                |
| <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> Measles         | <input type="checkbox"/> Tires easily        | <input type="checkbox"/> Bone or Joint Problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Bleeds freely          |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble   | <input type="checkbox"/> Rheumatic Fever     |   |

If your child had any of the above conditions, did he/she receive medical care?  Yes  No

2. Is your child on medication at this time:  Yes  No

If so what? \_\_\_\_\_ For What Condition? \_\_\_\_\_

3. Is your child under medical care at this time:  Yes  No

If so what? \_\_\_\_\_ For What Condition? \_\_\_\_\_

4. Is your child eligible for Medicaid?  Yes  No

5. Name of Insurance Company \_\_\_\_\_ Policy/Group# \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

In case of accident or serious illness, I request the Texas Hill Country Bass Collective to contact me. If the Texas Hill Country Bass Collective is unable to reach me, I hereby authorize the the Texas Hill Country Bass Collective to call the physician indicated below AND to follow his instructions. If it is impossible to contact this physician, the the Texas Hill Country Bass Collective may take whatever arrangements seem necessary. If unable to name a physician or pay for medical services, then medical, hospital or welfare services may be authorized. I understand that the Texas Hill Country Bass Collective does not carry insurance, catastrophic or other, on my child and that I am responsible for payment of any injuries incurred.

6. Known Drug Allergies: \_\_\_\_\_

7. Local Physician's Name: \_\_\_\_\_

8. Address: \_\_\_\_\_ Office Phone \_\_\_\_\_

9. Hospital preference in case of emergency: \_\_\_\_\_

I have completed all of the above information and do hereby confirm it is true and accurate.

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

All information on this form will be used only by the Texas Hill Country Bass Collective faculty and staff and will be kept private.