

Emergency Contact and Medical Information

2009-2010 ATX Winterguard

Please PRINT all information clearly and legibly.

† This section **must** be completed by a parent or guardian if member is under 18 years of age.

Member's Name	Date of Birth	M	F
		Sex	

Parent's/Guardian's Name (if Member is under 18)†

([])

([])

([])

([])

Home Phone

Work or Cell Phone

Parent/Guardian
Phone

Parent/Guardian
Work Phone

Address

Parent/Guardian Address

City, ST ZIP Code

Parent/Guardian City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact

Secondary Emergency Contact

([])

([])

([])

([])

Home Phone

Work Phone

Home Phone

Work Phone

Address

Address

City, ST ZIP Code

City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

Insurance Company

Policy Number

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Member's Signature or Parent/Guardian's Signature

Date

†

I release Austin Independent Winterguard, Austin Stars Performing Arts Association, and all instructional and administrative staff individuals affiliated with these organizations from liability in case off accident during activities related to Austin Independent Winterguard and Austin Stars Performing Arts Association, as long as normal precautions have been taken.

Member's Signature or Parent/Guardian's
Signature†

Date

Witness Signature

Date

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