Team 501 – PowerKnights Robotics Team
STUDENT HEALTH INFORMATION

NAME: _____ GRADE: ____

THE FOLLOWING WILL BE HELD CONFIDENTIAL BY THE FACULTY ADVISORS AND USED IN EVENT OF EMERGENCY
A COPY OF THIS DOCUMENT WILL BE AS EFFECTIVE AS AN ORIGINAL

Doctor: _____ Address: _____

Phone: _____ _____

Insurance Company: _____ Policy #: _____

Date of Last Tetanus Shot: _____

Preferred Hospital: _____

Does your child have any food, medicine, allergies, or any other conditions we should know about? If yes, please explain:

_____

_____

I/We **authorize** a licensed medical authority (EMT, RN, LPN and Outside Contractors of SAU #37) to administer first aid or for a doctor selected by Manchester High School West**, FIRST Robotics Team 501, The PowerKnights, and any representative thereof,** to hospitalize, secure proper treatment for, and to order medicine, injections, anesthesia, surgery or x-rays to my/our child following a robotics team related injury. I/We will not hold Manchester High School West responsible for any injury or repercussion from medical attention. I/We also give permission to transport my/our child to a medical facility for the purpose of obtaining medical care following an injury. EVERY ATTEMPT WILL BE MADE TO CONTACT YOU PRIOR TO ANY DECISIONS.

I/We give permission for a licensed medical authority to administer first aid or for a doctor to hospitalize, secure proper treatment, order medicine, injections, anesthesia, surgery or x-rays for my/our child following an injury. I/We will not hold Goffstown High School responsible for any injury or repercussion from medical attention. I/We also give permission to transport my/our child to a medical facility for the purpose of obtaining medical care following an injury. Every attempt will be made to contact you prior to any decisions. I agree to be financially responsible for any injury.

My child is physically able to participate in this robotics program. I understand that the 4-H members will be supervised, and that if a serious illness or injury develops, medical and/or hospital care will be given; however, the sponsor is not responsible in case of accident or illness. I further understand that in case of medical emergency we will be notified. In the event that I cannot be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named on this Medical Care and Treatment Form and do certify that the information set forth on this form is true and correct to the best of my knowledge. I will assume all financial obligations incurred if not covered by insurance.

WE REQUEST THAT BOTH PARENTS/GUARDIANS SIGN THIS FORM

Parent/Guardian: _____ Parent/Guardian: _____

Date: _____ Date: _____

EMERGENCY PHONE CONTACT

Home: _____ Home: _____

Work: _____ Work: _____

Cell: _____ Cell: _____

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