

BRIGADE DRILL TEAM & STEP SQUAD

Tacoma, WA (971) 704-2006



FAMILY MEDICAL INFORMATION: PARTICIPANT'S EMERGENCY INFORMATION & CONSENT FORM

Child's Name: _____
First MI Last

Home Address: _____
City State Zip

Insurance Policy Holder's Name: _____

Subscriber Date of Birth: _____

Carrier: _____ Policy# _____ Group: _____

Family Physician Name: _____ Phone# () _____

Allergies: _____

Serious Medical Conditions: _____

Does your child have any medical conditions that prohibit her/him from fully participating in the activities of the Brigade Drill Teams & Step Squad? Yes ☐ No ☐

Does your child have any of the following?:

- | | | | |
|---|------------------------------------|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Disorder | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Behavior Disorder | <input type="checkbox"/> Allergies | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Speech Disorder | <input type="checkbox"/> Other (List Below) |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hearing Impairment | |

Other (list other conditions from above here): _____

If you answered yes to any of the above; how are they managed the issues? _____

Is your child on any medication? Yes ☐ No ☐ If yes list here: _____

Please read the statement below and sign your name at the bottom.

I, _____, am the parent or guardian having legal custody of the child named above. I authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I/we hereby grant consent to any and all health care providers designated by the Brigade Drill Teams & Step Squad's Executive Director or his/her designee to provide my child _____, any necessary medical care as a result of any injury/illness. This consent includes First Aid and transportation to/from health care providers.

CONSENT OF PARENT OR GUARDIAN

Signature: _____ Date: _____

Please Designate: Parent ☐ Legal Guardian ☐