

WBL Insurance and Emergency Information

Student Name:	Work Site:
Address:	Address:
City: Zip:	City: Zip:
Phone:	Phone:
DOB: Grade:	WBL Coordinator:

Allergic to Medication? No Yes If yes: list medication(s): _____

List any other allergies or medical problems: _____

Medical Alert: No Yes, If yes: additional explanation: _____

Insurance Company: _____ Policy #: _____

Parent/Guardian	Home Phone: Work Phone: Cell Phone:
Parent/Guardian	Home Phone: Work Phone: Cell Phone:
Additional Emergency Contact	Home Phone: Work Phone: Cell Phone:

I consent for my child to receive medical treatment in case of injury or illness. The information provided is accurate to the best of my knowledge.

Parent or Guardian	Date
Student	Date
WBL Coordinator	Date
Principal	Date
Supervisor	Date

Note: It is the policy of the school district that no person on the basis of race, color, religion, national origin or ancestry, age, sex, marital status, disability, or disadvantage should be discriminated against, excluded from participation in, denied the benefits of or otherwise be subjected to discrimination in any program or activity. This form is subject to monitoring by TDOE and/or TDOL&WD.