

## WBL Insurance and Emergency Information Form

<b>Student Name:</b>		<b>Worksite:</b>	
<b>Address:</b>		<b>Address:</b>	
<b>City:</b>	<b>Zip:</b>	<b>City:</b>	<b>Zip:</b>
<b>Phone:</b>		<b>Phone:</b>	
<b>DOB:</b>	<b>Grade:</b>	<b>WBL Coordinator:</b>	

**Is the student allergic to any medications?** If so, list the medication(s): \_\_\_\_\_

\_\_\_\_\_

List any allergies or other medical concerns: \_\_\_\_\_

\_\_\_\_\_

**Medical Alert(s)** (if applicable) \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

<b>Parent/Guardian 1:</b>	<b>Phone:</b>
	<b>Alternative Phone:</b>
<b>Parent/Guardian 2:</b>	<b>Phone:</b>
	<b>Alternative Phone:</b>
<b>Additional Emergency Contact:</b>	<b>Phone:</b>
	<b>Alternative Phone:</b>

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.

<b>Student:</b>	<b>Date:</b>
<b>Parent or Guardian:</b>	<b>Date:</b>
<b>WBL Coordinator:</b>	<b>Date:</b>
<b>Principal:</b>	<b>Date:</b>
<b>Worksite Supervisor:</b>	<b>Date:</b>

**Nondiscrimination:** No person shall be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in connection to this program and activities or in employment practices on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by federal or state law. This form is subject to monitoring by the Tennessee Department of Education and Tennessee Department of Labor & Workforce Development.