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 again, excluded from participation in, denied the benefits of or otherwise be subjected to discrimination in nay program or activity. This form is subject to monitoring by TDOE and/or TDOL&WD.