Billings Public Schools
Student Participant in Activities
Emergency Medical Card and Authorization for Medical Treatment

1. Participant's Name _____

2. Person and phone number to contact in case of emergency:

   Name _____ Phone #: _____

3. Family physician and phone number:

   Name _____ Phone #: _____

4. Medical Information: Allergies, Diabetic, etc. :

   _____

   _____

5. Insurance Company: _____ Policy #: _____

6. I/We, parent(s)/guardian(s) of the above named participant, authorize medical treatment to be given to the above named student.

   _____ _____

   Parent or Guardian Signature Date