Wilson Memorial High School

189 Hornet Road
Fishersville, VA 22939
(540) 886-4286

MEDICAL INFORMATION

Student Name ________________________________ Date of Birth_______________
Address ___________________________ City/State/Zip _________________________
Home Phone ________________________
Emergency Phone Number _______________________
Parent/Guardian Name____________________________
Does student have insurance through parent/guardian employer? ________
If yes, name of company _______________________ Policy Number _______________
Cell Phone with you on Trip ________________________

Health History (check)
_____ Diabetes
_____ Orthopedic Problems
_____ Asthma
_____ Epilepsy
_____ Cardiac Problems
_____ Other (specify)

Allergies (check)
_____ Aspirin
_____ Penicillin
_____ Sulfa
_____ Insect Stings
_____ Tetracycline
_____ Other (specify)

Do we have permission to administer to your child? (check)
_____ Aspirin _____ Tylenol _____ Advil

Date of your last tetanus shot ____/____/________

Is your child currently taking any medications? If yes, please list the name and dosage amount and times.

1. ____
2. ____
3. ____
4. ____

Do you have any food allergies or dietary needs if the group will be supplying meals? _______

1. ____
2. ____

I give permission to the physician or hospital to secure proper treatment for and to order medications, injections, anesthesia or surgery for my child as named above.

___________________________________ ____________________
(Signature of Parent) (Date)