

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 number that you will have on trip with you _____

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

Has your child had a tetanus shot current to within six years? _____

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

1. _____
2. _____
3. _____
4. _____

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? If yes, please explain.

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)