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)