West Deptford High School
Medical Questionnaire and Emergency Treatment Authorization Form

Please type or print

Student's Name: Last:_____ First: _____M.I:_____

Student's Social Security # _____/_____/_____ Date of Birth _____ Age _____

Address _____
Street City State Zip Code

Person to be contacted in case of emergency_____

Relationship to student_____ Home Phone # _____ Work Phone_____

Alternate Contact _____

Relationship to student_____ Home Phone # _____ Work Phone_____

Name of Family Physician _____ Phone (_____)_____

Doctor's Address _____
Street City State Zip Code

Name of Health Insurance Co. _____Policy # _____

Please answer YES or NO to each of the following:

1. Will your son/daughter be taking medication of any type during the trip? _____ If yes, please specify: _____
_____
_____

2. Has he/she ever been treated for: (if currently being treated, please indicate)

A. Nervousness? _____
B. Any Medical Disorders? _____
C. Convulsions/Epilepsy? _____
D. Fainting Spells? _____
E. Heart Conditions? _____
F. Rheumatic Fever? _____
G. Cancer or Tumor? _____
H. Arthritis? _____
I. High Blood Pressure? _____
J. Migraines/Headaches? _____
K. Asthma? _____
L. Ulcers? _____
M. Diabetes? _____
N. Sensitivity to the Sun? _____

O. Allergic Reactions To Medication? _____
Aspirin? _____
Penicillin? _____
Sulfur? _____
Tetracycline? _____
Other Medications?
_____
_____
_____

P. Any Other Allergic Reactions?
Food? _____
Insect Stings? _____
Other?
_____
_____

3. Give details for any replies of "Yes above. _____
_____
_____

4. Has you child had a current tetanus shot? _____ When? _____

5. Does he/she have any other physical limitations? _____
_____
_____

Please Read Carefully

I hereby certify that the information given above is correct. In case of medical emergency, I understand that every effort will be made to contact the person designated above. In the event that person cannot be reached, or time does not permit, I hereby give permission to a licensed physician or hospital to provide proper treatment, including hospitalization, immunization or injection, anesthesia or surgery for my son/daughter. I further understand that I am liable for all costs incurred and not covered by my insurance. School insurance will cover expenses for accidents which exceed the amount of coverage provided by the parents' insurance up to usual and customary charges.

Signature of Parent/Guardian **X** _____ Date _____
Witnessed by (must be an adult not related to Parent/guardian):

X_____ _____ Date _____
Witness Signature Print name of witness