

**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. If 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