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