



West Salem High School  
1776 Titan Drive NW Salem, OR 97304 503 399-5533

### HEALTH FORM

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First M.I.

Name of Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
Cell Home

Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_  
Name Cell Home

Does student have School Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_

Parent/Guardian Insurance \_\_\_\_\_ Company/Policy no. \_\_\_\_\_

Allergies: a. Food(s) \_\_\_\_\_

b. Medication(s): \_\_\_\_\_

What medications does student take: \_\_\_\_\_

Does student need chaperone to dispense medication? Yes \_\_\_ No \_\_\_ If yes, please send medication(s) and instructions for dosage, frequency, and time of day to be dispensed.

Has student had medical attention or seen a doctor about (Circle all that apply):

- |                               |                           |
|-------------------------------|---------------------------|
| Epilepsy                      | Rheumatic Fever           |
| Dizziness/fainting spells     | Asthma                    |
| Eye, Ear, Nose/Throat Trouble | Palpitation of heart      |
| Frequent colds                | Jaundice or Hepatitis     |
| Hay fever                     | Kidney or Urinary Trouble |
| Diabetes                      | Bee Sting Allergies       |
| Stomach Trouble               | Other _____               |

The school has my permission to call my family physician or another physician in an emergency when family physician or I cannot be contacted.

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Alternate Physician \_\_\_\_\_ Phone \_\_\_\_\_

**CAUTION**

By law, a parent cannot consent in advance to any and all manner of emergency care. It is understandable that in cases, other than the need for immediate emergency treatment, the attending physician may defer treatment pending the parent's express permission to administer specific professional service.

My student \_\_\_\_\_, has my permission to travel with the West Salem High School Choir Department to Vancouver British Columbia May 23 – May 26, 2019. We have read the "Rules of the Road" and agree to abide by them on the trip.

Print student Name

\_\_\_\_\_ Date \_\_\_\_\_  
Print Parent/Guardian

\_\_\_\_\_ Date \_\_\_\_\_  
Signature Parent Guardian

**RETURN TO MS. MAC BY Monday May 13, 2019.**

Name of Student \_\_\_\_\_

Student Number \_\_\_\_\_ School \_\_\_\_\_

**PARENT PERMISSION FOR SCHOOL TRIP**

In order for my child, a minor, named above to take part in and receive the advantages of a program planned and sponsored by Salem-Keizer School District 24J, Marion County, Oregon, I am hereby giving permission for him/her to make any or all of the trips included in the planned program of the school.

Transportation may be provided at the discretion of the School District in such form as is approved by the Superintendent.

I authorize 24J and its employees to secure the services of a physician or hospital, and to incur expenses for necessary services in the event of accident or illness, and I will provide payment for these. Every reasonable effort will be made to reach the parent(s) as soon as possible.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian

Address \_\_\_\_\_

*It is important that parent/guardian retain copy for reference throughout the year.*