



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
Print student Name

School Choir Department to Vancouver, Canada May 26 – May 29, 2016. We have read the "Rules of the Road" and agree to abide by them on the trip.

_____ Date _____
Print Parent/Guardian

_____ Date _____
Signature Parent Guardian

RETURN TO MS. MAC BY MONDAY MAY 23, 2016