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 San Francisco May 25 – May 30, 2017. 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 Friday May 19, 2017.