West High Entertainment Unit (WHEU)- Student Medical Form

School:_____ Date:_____
Student's Last Name:_____**First Name:**_____
Mother's Name:_____Home Phone:(___)_____
Work Phone:(___)_____ Cell Phone:(___)_____
Father's Name:_____Home Phone:(___)_____
Work Phone:(___)_____ Cell Phone:(___)_____

Emergency Contact Person:
Name:_____Relationship to Student:_____
(Not a parent or traveler)
Home Phone:(___)_____ Work Phone:(___)_____
Cell Phone:(___)_____

Health Insurance Co:_____Subscriber:_____
Policy Number:_____Insurance Co. Phone Number:(___)_____
Prescription Provider:_____Subscriber:_____
Policy Number:_____Prescription Provider Phone Number:_____
Family Physician's Name:_____Phone Number:(___)_____
Date of Last Tetanus Shot:_____ (*Include Copy of Insurance and Prescription Card*)
Student's Date of Birth:_____Height:_____Weight:_____

Is the student required to take any prescription medication: **Yes____No____**
If yes, additional form required. Keep medicine in original bottles. (All medications will be dispensed by a chaperone.)

Does the student carry an inhaler? **Yes____No____**When should this be used and is there any warning symptoms?
Please explain:_____

Does the student carry an Epi Pen? **Yes____No____**When should this be used and is there any warning?
Please explain:_____

Indicate which nonprescription medications your child has your permission to carry and use during the trip.

YES	NO		YES	NO	
____	____	Immodium,or Kaopectate (for diarrhea)	____	____	Bonnie, or Dramamine (motion sickness)
____	____	Pepto Bismol (for upset stomach)	____	____	Throat Lozenges (sore throat)
____	____	Caladryl (for skin rashes)	____	____	Tylenol (Acetaminophen)
____	____	Advil or Motrin (Ibuprofen)	____	____	Benadryl (antihistamine)
____	____	Sudafed (decongestant)	____	____	Midol
____	____	_____	____	____	_____

I will allow my student to take the over the counter medicines marked yes, as needed.
Parent Signature: _____

Check all applicable conditions of student and explain below:

[] Allergy to bee stings
[] Asthma
[] Backaches or weak back
[] Bowel or bladder problems
[] Car/sea sickness
[] Diabetes
[] Hay fever
[] Bloody Nose
[] Respiratory problems
[] Sinus trouble
[] Sleep Walking
[] Vomiting
[] Epilepsy or convulsive disorder
[] Headache
[] Heart trouble or murmur
[]Other:_____

Does student have any restrictions to physical activity? **Yes ____No ____**
If yes please explain:_____

Any other important medical needs or conditions? **Yes ____ No ____**
Explain:_____

Any food, or medicine allergies? **Yes ____ No ____**
Explain: _____

Does student have any dietary restrictions? **Yes ____ No ____**
Explain: _____

Is your student allergic to:
Poison Ivy? **Yes ____ No ____ Don't know____**
Poison Oak? **Yes ____ No ____ Don't know____**
Poison Sumac **Yes ____ No ____ Don't know____**

Signature _____Date _____
Parent or Legal Guardian
Please Print Name: _____