WVHS **MARCHING WARRIORS**

MEDICAL INFORMATION FORM

Please complete this form as clearly and accurately as possible. This information is needed so that staff can be informed of special needs and medical conditions to ensure the health of each member. This information will be held in the strictest confidentiality.

PLEASE PRINT OR TYPE

Student's Name	Date of Birth
Parent / Guardian's Name	Person to Contact in Case of Emergency
Address	Emergency Phone
City, State, ZIP	Family Physician
Home Phone	Physician Phone
Parent's Work Phone(s)	Insurance Company & Policy Holder
Parent's Work Phone(s)	Policy Number

MEDICATIONS (currently taking):	DOSAGE / FREQUENCY:

Date of last Tetanus shot: _____

Allergies/allergic reactions to medications:

_____

_____

Major surgery: _____

_____

Acute or chronic medical conditions: _____

_____

Physical conditions that may limit activity: _____

Special dietary needs: _____

PARENTAL CONSENT FORM/RESPONSIBILITY CLAUSE/MEDICAL PERMIT

PLEASE FILL OUT COMPLETELY.

I hereby give permission for _____ to participate in the MARCHING WARRIORS. I understand that WVHS, its officials, and chaperones shall not be, nor later become, liable or responsible in any way in conjunction with services, for any death, injury, damage, delay or irregularity which may occur while participating in this activity.

In the event that my student needs to take a prescription or non-prescription medication while participating, I give my child permission to use this medication. ALL medications, prescription or non-prescription, must be carried in the original labeled container. Prescription medications must be listed on the medical consent permit unless prescribed by a medical professional during an emergency.

Also, in case of emergency, I hereby give my consent for a qualified physician to perform any medical or surgical procedures he/she deems necessary to the welfare of my child. It is also understood that the staff or chaperones and medical personnel will make every attempt to contact parents, guardians, or relatives listed above when taking any such actions. Further, this authorization permits said physician to hospitalize, secure appropriate consultation, order injections, anesthesia (local, general or both) or surgery for my child if such emergency conditions warrant.

In addition, if a licensed physician is asked to provide medical care, I authorize this physician to examine and treat my child for general medical problems of a non-emergency nature (colds, sore throat, vomiting, diarrhea, insect bites, heat exhaustion, etc.) that may arise while participating.

Signature: _____ Relationship To Student: _____ Date: _____ / / _____