

West Orange High School

Medical Form Boston, Massachusetts May 30 through June 2, 2008

Please print all information:

Name _____
(Last) (First) (Middle Initial)

Address _____

Home Telephone # _____

Father's Name _____ Business Phone _____ Cell- _____

Mother's Name _____ Business Phone _____ Cell- _____

Birth Date _____

Reliable person other than parent to be called who could locate parents in case of an emergency

Name _____ Telephone # _____

Permission for emergency treatment in a local hospital:

[] Yes [] No _____
(Signature)

Date of most recent Tetanus Vaccine _____

Health Insurance _____
Company Name I.D. #

History of Any chronic illness _____

Allergies (please list) _____

Please list all medications your child is taking, the dosage and the time they are to take it. **(please be aware that your child will be responsible or taking their own medication)** All medications **must** be in their original containers.

Type of Medication Dosage Time/Interval to be taken

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