

2008-09 Medical History & Permission

Last Name: _____	First Name: _____
Street Address: _____	
City: _____, South Carolina	Zip: _____ Home Phone: _____
Date of Birth: _____	Age: _____ Grade: _____ SSN #: _____

Is the student allergic to any medication and/or food? _____ Which? _____

In case of sickness, may this student take: Aspirin? _____ Iduprofen? _____ Imodium AD? _____

Does this student wear contact lenses? _____ Prescription glasses? _____

Does this student suffer from: Hay fever? _____ Allergies? _____ Asthma? _____

Does this student take any medication? _____ Which? _____

Any other health history that may assist the person in charge should this student become ill?

IN THE EVENT OF AN EMERGENCY:

Parent or Guardian Name(s): _____

Home Phone: (_____) _____ Mother Work: (_____) _____

Mother Cell: (_____) _____ Father Work: (_____) _____

Father Cell: (_____) _____ Other Phone: (_____) _____

FAMILY PHYSICIAN:

Name: _____ Phone: (_____) _____ Other Phone: _____

OTHER EMERGENCY CONTACT(S)

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

WE DO [] WE DO NOT [] HAVE HEALTH OR ACCIDENT INSURANCE

Insurance Company Name: _____

Group Number: _____ Policy Number: _____

Please attach a copy of your insurance card to this form.

This is permission for treatment of this child by a physician and/or at a hospital for any medical or surgical emergency. I also relieve White Knoll High School, Lexington County, Lexington School District One and its Board, the Administrators, Teachers, Staff, and Chaperones of any liability for any accident that may occur under reasonably prudent supervision.

Signature of Parent or Guardian

Signature of Parent or Guardian

Date