

Name of Student: \_\_\_\_\_

**West Virginia Governor's Schools Emergency Contact and Medical Information**

The information on this form is gathered to assist us in identifying appropriate care. Any changes of the information on this form after it is sent should be provided to the WVGSMs personnel upon your arrival. Provide complete information so that the GSMS can be aware of you needs. Please notify GSMS immediately if exposed to a communicable disease during the four weeks prior to arrival.

**Emergency Contact #1**

Day Telephone	Evening Phone	Cell Phone
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**Emergency Contact #2**

Full name	Relation to Student	
Day Telephone	Evening Phone	Cell Phone

**Family Physician**

Full Name	Day Phone	Evening Phone
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**Permission to Provide Necessary Treatment or Emergency Care**

As the legally recognized parent or guardian of the individual named above, by signature below I hereby give authority and permission to the WVGSMs and its staff and licensed medical professionals to obtain and provide necessary medical treatment including, but not limited to, diagnostic X-rays, routine tests, and treatment, including hospitalization; to release many records necessary for medical or insurance purposes; to provide or arrange necessary related transportation for my child; to administer, as needed, the over-the-counter medications listed below (strike through any exceptions); and to copy this completed form which will accompany the student on trips outside the host campus. I understand that every practical effort will be made to contact me or other parents or guardians of the student if a medical emergency occurs. I have also enclosed a copy of both sides of the medical insurance card that covers the individual named above.

Over-the-Counter Medications and Indications

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Topical sunscreen for sun exposure</li> <li>• Topical Bug Repellent</li> <li>• Maalox/Tums (and similar produces) for upset stomach</li> <li>• Milk of Magnesia for constipation</li> <li>• Kaopectate or Ammodium for diarrhea</li> <li>• Anti-itch lotion</li> <li>• Benadryl (generic)</li> </ul> | <ul style="list-style-type: none"> <li>• Antibiotic Ointment</li> <li>• Cough Tylenol for fever, pain, headache</li> <li>• Ibuprofen for fever, pain, headache</li> <li>• Throat lozenges for sore throat</li> <li>• Dramamine or its generic for motion sickness</li> <li>• Benedrine and Epinephrine for sever anaphylactic reaction</li> <li>• Cough syrup</li> <li>•</li> </ul> |
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Signature of Student	Date	Signature of Parent/Guardian	Date
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**General Questions (Check appropriate column)**

	Y	N		Y	N
Has/does the student					
1. Had any recent injury, illness or infectious disease?			15. Ever been diagnosed with a heart murmur?		
2. Have a chronic or recurring illness or condition?			16. Ever had back problems?		
3. Ever been hospitalized?			17. Ever had problems with joints, e.g., knees or ankles?		
4. Ever had surgery?			18. Have any skin problems?		
5. Have frequent headaches?			19. Have asthma?		
6. Ever had a head injury?			21. Had mononucleosis in past 12 months?		
7. Ever been knocked unconscious?			22. Had problems with diarrhea/constipation		
8. Wear eyeglasses/contacts/protective eyewear?			23. Have problems with sleepwalking?		
9. Ever had frequent infections?			24. Have a history of bed-wetting?		
10. Ever passed out during or after exercise?			25. If female, abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			26. Ever had an eating disorder?		
12. Ever had seizures?			27. Ever had emotional difficulties requiring professional help?		
13. Ever had chest pain during or after exercise?					
14. Ever had high blood pressure?					

Please explain any "yes" answers, noting the number of the questions (attach additional pages as necessary)


This is Page 1 of 2 of the Medical Information. Do not write on the back.

Name of Student \_\_\_\_\_

Medical Information Page Two

Please list any chronic conditions such as asthma or diabetes

1.	2.	3.
4.	5.	

List all prescribed medications the student will bring. Prescriptions must be in the original package of bottle that identifies the prescribing physician, the name of the medication, the dosage and frequency of administration. Medication be kept and dispensed by a staff member.

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Date of last Tetanus booster:

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Allergies

Medication Allergies:

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Food Allergies:

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Other allergies (Please include stings and environmental allergies)

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Parent and Student Statements

This health history is correct and complete.

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Signature of Student

Date

Signature of Parent

Date