

MEDICAL HISTORY
Willamette Valley Christian School
2010-2011

To be filled in by parent or guardian: (please print)

Pupil's Name _____ Date _____ Grade _____
 Date of Birth _____ Home phone _____

Address _____

Name of parent or guardian _____ Business phone _____

Person to contact in case of emergency and you cannot be reached:

Name _____ Phone _____

Address _____

Name of physician to be called in an emergency _____ Phone: _____

Circle the following that your child has now or has had in the past:

Concussion	yes no year _____	Operations	yes no year _____
Skull fractures	yes no year _____	Exposure to Tuberculosis	yes no year _____
Neck injuries	yes no year _____	Rubella (3 day Measles)	yes no year _____
Back injuries	yes no year _____	Rubella (7 day Measles)	yes no year _____
Muscle, bone, joint disease	yes no year _____	Mumps	yes no year _____
Skin disorders	yes no year _____	Rheumatic Fever	yes no year _____
Eye glasses	yes no year _____	Scarlet Fever	yes no year _____
Contact lenses	yes no year _____	Chicken Pox	yes no year _____
Visual treatments	yes no year _____	Urinary tract infections	yes no year _____
Treatment underway	yes no year _____	Urinary tract disorder	yes no year _____
Hearing treatments	yes no year _____	Allergic disorders: (circle)	
Treatment underway	yes no year _____	insect stings	food
Hernia	yes no year _____	pollens	medicines
Diabetes	yes no year _____	dust	other _____
Seizure disorder	yes no year _____	Currently on long term	
Fainting spells	yes no year _____	medication or shots	yes no year _____
		Any other significant	
		handicap or illness	yes no year _____

Parent's comments on anything checked "Yes" above, as well as any comments regarding behavior and any physical problems or injuries: _____

IMMUNIZATIONS

Every child aged 5-14 years entering Oregon public, private, or parochial schools for the first time must present evidence that their immunizations are complete and up to date. Exceptions are possible under some circumstances.

I hereby give permission for my child to receive emergency medical care, and the information on this document may be made available to school authorities.

Date _____ Signature of parent / guardian _____

ANNUAL FIELD TRIP RELEASE/EMERGENCY MEDICAL FORM

Willamette Valley Christian School
9075 Pueblo Ave. NE
Salem, OR 97305

2010-2011 School year

This form will be on file at the school office for the current school year. An additional Permission to Participate form will be sent home prior to each off-campus trip.

I give my permission for _____, grade _____, to participate in all sports and school-sponsored trips away from the school premises throughout the current school year. Students will be accompanied by a teacher and will be under adequate supervision.

I/We understand that there are risk/dangers involved with participation in off-campus trips and their associated activities. In consideration of my child being allowed to participate in this event, I/we assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I/We agree to hold harmless Willamette Valley Christian School, its affiliated organizations, employees, agents, and representatives, including volunteer and other drivers, from any and all claims arising from my child's participation. This release agreement does not apply to claims of intentional (criminal) misconduct or gross negligence by the school, its employees, or volunteers. If such circumstances are proved in a court of law, I/we acknowledge and agree that the school can assume no financial liability beyond its actual liability insurance policy in force.

In case of accident, illness, or other emergency, I/we request that the school contact me. If the school cannot reach a parent/guardian after conscientious effort, I/we give permission for school staff to call paramedics or any licensed physician or dentist. If a life-threatening emergency exists, I/we give permission for school staff to call paramedics immediately and then contact me/us as soon as possible thereafter.

I/We authorize and consent to an X-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which, in the best judgment of a licensed physician or dentist is deemed advisable. I/We agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/We agree to be financially responsible for emergency medical transportation.

Father/Guardian Signature and Date

Mother/Guardian Signature and Date

Printed name

Printed name

If the child lives with both parents, the release must be signed by both parents/guardians.

Home phone _____

Address: _____

Father's work phone: _____ Father's cell phone or pager: _____

Mother's work phone: _____ Mother's cell phone or pager: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Health Insurance Carrier: _____

Under the name of: _____ Policy # _____

Allergies: _____ Medication _____ being taken: _____

Preferred Hospital: _____ Date of last tetanus shot: _____

Physical or medical conditions: _____

In case of emergency, who is nearest relative or neighbor we should contact if we are unable to contact you at home or work?

Name: _____ Relationship: _____ Phone: _____

