WHS Student Health Form

Student Name :________________________ Home phone #:____________

Address:______________________________ Cell phone #:____________

DOB:______________ Age:____ Sport(s):______________________________

Mother's Name:____________________ Address:____________________

Home #:____________ Cell #:______________ Work #:________________

Father's Name:____________________ Address:____________________

Home #:____________ Cell#:______________ Work#:________________

Emergency Contact:______________________ Phone #:________________

Relationship to Athlete:_______________________

Family Doctor:_______________________ Office #:________________

Known Allergies:____

Medications (currently taking):___________________________________

Chronic Medical Conditions (i.e. seizures, diabetes, asthma)________________

____