WCASD-EMERGENCY MEDICAL CARD
PLEASE PRINT LEGIBLY

STUDENT'S NAME_______________ Last Name _______________ First _______________ M.I. PHONE _______________
BIRTH DATE_______________ GRADE _______ H.R.__________
Resides with: Father__________ Mother_______ Both_________ Guardian (Name) _______________

Father's Name_______________
Address_______________
City _______________ State ____ email_______________
Zip Code_______ Home Phone_______________
Business Name_______________
Phone_______________ Cell Phone_______________

Mother's Name_______________
Address_______________
City____________ State___ email_______________
Zip Code_______ Home Phone_______________
Business Name_______________
Phone_______________ Cell Phone_______________

Siblings in School _______________

IF PARENT/GUARDIAN CAN NOT BE REACHED, PLEASE PROVIDE A LOCAL CONTACT:

1. Relationship _______________
Name _______________
Address _______________
Phone (H)_______________ (W)_______________

2. Relationship _______________
Name _______________
Address _______________
Phone (H)_______________ (W)_______________

DOCTOR _______________ DENTIST _______________ ORTHODONTIST _______________
PHONE _______________ PHONE _______________ PHONE _______________
SPECIALIST _______________ PHONE_______________

PLEASE NOTE NEW PROCEDURE- All non-prescription and prescription medications must have both a doctor's order and a parent note in order to be administered. The medication must be in the original container with original label. If prescription, it must have the name of the student to whom it is to be given. WCASD nurses already have standing orders to give the following: Tylenol, Benadryl and antacids. You may give us written permission now to give your student those medications when we decide they are necessary, by marking "yes" next to each below.

TYLENOL Yes _____ No____ **IBUPROFEN** Yes ____ No_____ **BENADRYL** Yes ____ No_____ **ANTACID** Yes____ No____
(Tylenol will be given for temps overs 100 degrees only upon request of the parent/guardian. Benadryl will be given for allergic reactions only)

Antibiotic Ointment Yes_________ No_______________

MEDICAL INFORMATION WILL ONLY BE SHARED WHEN APPROPRIATE AND/OR ON A "NEED TO KNOW BASIS"!

1. Circle any medical condition:

MEDICAL COND	Treatment/Rx	MEDICAL COND	Treatment/Rx	MEDICAL COND	Treatment/Rx
ADD/ADHD		GASTROINTESTINAL		ALLERGIES:	
ASTHMA		CARDIOVASCULAR		FOOD	
DIABETES		ORTHOPEDIC		DRUG	
OTHER		MIGRAINES		INSECT	
		SEIZURE DISORDER		ENVIRONMENT	

2. Is student taking any medication? Home? ____ School? ____ What and Why?_______________
3. Has student been hospitalized the past year? Yes ____ Explain:_______________

AUTHORIZATION FOR EMERGENCY SERVICES TREATMENT OF MINOR

1. The undersigned is the parent/legal guardian of the minor named below.
2. This authorization is being provided for use in the event of the need for emergency treatment of the minor named below, when neither the undersigned, nor the relative/friend identified (front card), nor HCP can be reached to provide consent to treatment.
3. The undersigned authorizes WCASD to solicit emergency medical treatment for the minor named below, from providers of such treatment, in the locale of the emergency service dept, when such treatment is determined necessary by WCASD.
4. Undersigned authorizes the friends, relatives and health care providers identified (front of card) to authorize the administration of emergency medical treatment to the minor named below, in situations where the undersigned cannot be reached.
5. The undersigned hereby authorizes health care providers of the emergency services departments of their designee (who must be a fully licensed physician) to perform on the minor named below, such emergency treatment or procedures as deemed appropriate, provided, however, that my consent or consent of the health care provider, friend, or relative identified above will first be sought, unless the delay in communicating with such person is, in the opinion of the health care provider, imprudent under the circumstances.

Minor's Name_______________
Health/Hospitalization Insur _______________
Policy Number_______________
Insurer_______________

"
*****I give permission for my child's health record and/or copy to be sent upon written request to a school and/or agency. I give permission for immunization**
"
information to be obtained from my doctor. YES_____________ NO________________

SIGNATURE OF PARENT/GUARDIAN_______________ DATE ____________

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