REQUIRED OF ALL STUDENTS - BRING TO NURSE'S OFFICE THE FIRST WEEK OF SCHOOL EACH YEAR PLEASE!

WCASD - EMERGENCY MEDICAL CARD

Student ID # | Last Name | First Name | Middle | Telephone | Grade | Homeroom | Birthdate

Parent Guardian Info:

Relation: | Last Name: | First Name: | Address: | Home Phone: | Resides

Employer: | Work Phone: | Cell Phone: | Email

Relation: | Last Name: | First Name: | Address: | Home Phone: | Resides

Employer: | Work Phone: | Cell Phone: | Email

IF PARENT/GUARDIAN CANNOT BE REACHED, CONTACT:

Relation: | NAME: | Address: | City: | State: | Telephone:

Relation: | NAME: | Address: | City: | State: | Telephone:

Physician | Dentist | Orthodontist | Specialist

Phys. Phone | Dentist Phone | Orthodontist Phone | Specialist Phone

 # to be called in case of school emergency closing (ONE direct number only- no extension):

Name/School of siblings attending WCASD:

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 doctor's orders to give the following: Tylenol, Advil, Benadryl and Tums. You may give us written permission now to give your student those medications when we decide they are necessary, please mark with a yes or no next to each of these four medicines.

Tylenol? _____ **Advil?** _____ **Benadryl?** _____ **Antacid?** _____

Tylenol will be given for temps over 100 degrees only upon the request of the parent/guardian. Benadryl will be given for allergic reactions only.

Circle any medical condition:

ADD/ADHD | ASTHMA | GASTROINTESTINAL | ALLERGIES:
CARDIOVASCULAR | DIABETES | ORTHOPEDIC | FOOD
MIGRAINES | SEIZURE DISORDER | DRUG
OTHER: | INSECT
ENVIRONMENT

Is this student taking any medication at home or school? **Medications:**

Has student been hospitalized in the past year? Explain:

AUTHORIZATION FOR EMERGENCY SERVICES TREATMENT OF MINOR:

1. The undersigned is the parent/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, 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 above 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: **Policy Number:**

Health/Hospitalization Insur: **Insurer:**

I would like information about health insurance for my child (please circle yes or no): YES NO

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.

SIGNATURE OF PARENT/GUARDIAN _____ **DATE:** _____