

WCASD-EMERGENCY MEDICAL CARD

STUDENT'S NAME _____ Last Name _____ First _____ DOB: _____ Grade: _____ HR _____

Resides with: Father _____ Mother _____ Both _____ Guardian (Name) _____

Father's Name _____

Mother's Name _____

Address _____

Address _____

City _____ State _____ email _____

City _____ State _____ email _____

Zip Code _____ Home Phone _____

Zip Code _____ Home Phone _____

Business Name _____

Business Name _____

Phone _____ Cell Phone _____

Phone _____ Cell Phone _____

Day Care Facility Name and Phone _____

IF PARENT/GUARDIAN CAN NOT BE REACHED, CONTACT:

1. Relationship _____

2. Relationship _____

Name _____

Name _____

Address _____

Address _____

Phone (H) _____ (W) _____

Phone (H) _____ (W) _____

DOCTOR _____ DENTIST _____

ORTHODONTIST _____

PHONE _____ PHONE _____

PHONE _____

SPECIALIST _____ PHONE _____

All over the counter (OTC) and prescription medications must have both a doctor and parent note to be administered during school. The medication must be in the original, labeled container. WCASD nurses have standing orders to give the following: Tylenol, Advil, Benadryl and Antacids. Please indicate your permission below.

TYLENOL Yes ___ No ___ ADVIL Yes ___ No ___ BENADRYL Yes ___ No ___ ANTACID Yes ___ No ___ (Benadryl will be given for allergic reactions only)

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

1. Circle any medical condition:

Table with 6 columns: MEDICAL COND, Treatment/Rx, MEDICAL COND, Treatment/Rx, MEDICAL COND, Treatment/Rx. Rows include ADD/ADHD, ASTHMA, DIABETES, OTHER, GASTROINTESTINAL, CARDIOVASCULAR, ORTHOPEDIC, MIGRAINES, SEIZURE DISORDER, ALLERGIES, FOOD, DRUG, INSECT, 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.

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 _____