WCASD-EMERGENCY MEDICAL CARD

STUDENT'S NAME_____ DOB:_____Grade:____ HR_____
Last Name First

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_____

Day Care Facility Name and Phone_____

IF PARENT/GUARDIAN CAN NOT BE REACHED, CONTACT:

1. Relationship _____
Name _____
Address _____
Phone (H)_____(W)_____
DOCTOR _____DENTIST _____ORTHODONTIST _____
PHONE _____PHONE _____PHONE _____
SPECIALIST _____PHONE_____

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

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. Consent stays in effect until revoked in writing.

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:

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.

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 _____

M-12A REV 3/15, 1/18