**STUDENT'S NAME: _____ Date of Birth: ____/____/____ Grade: _____**

Please fill out the following information to ensure the safety of your child during the school day. The school will make every effort to contact you in the event of an accident or sudden illness.

## EMERGENCY MEDICAL INFORMATION

Does your child have any of the following:

Drug allergies: _____

Environmental Allergies: _____

Allergies to Bug Bites/Stings: _____ EPI-PEN Prescribed_____

Food allergies/Dietary Restrictions: _____ EPI-PEN Prescribed_____

Asthma: _____Inhaler Prescribed _____

Other Medical Illnesses/Conditions/Concerns:

_____

Does your child wear: Glasses____ Contacts____ Braces____ Retainer____ Hearing Device____

_____

**Student's Medical Doctor** **Address** **Telephone**

_____

**Student's Dentist/Orthodontist** **Address** **Telephone**

**Medical Insurance Co._____ Ident./Group#_____**

In case of a medical emergency involving my child I grant permission to the WPS to provide medical treatment and transport via ambulance to the nearest medical facility.

***X***_____

**Signature of Parent/Guardian** **Date**

## EMERGENCY CONTACT INFORMATION

**Names of 2 persons who may be called or to whom your child may be released in case you cannot be reached.**

_____

**Name** **Address** **Telephone/Cell**

_____

**Name** **Address** **Telephone/Cell**

## ADMINISTRATION OF OVER THE COUNTER MEDICATION TO MY CHILD BY SCHOOL NURSE

I consent to the following medications to be given to my child as needed for injury or illness, unless otherwise noted.

*Place a checkmark next to the medication(s) you authorize the school nurse to administer to your child.*

Ibuprofen____ Tylenol____ Benadryl____ Tums____ Bacitracin/Neosporin/Hydrocortisone 1% creams____

***X*** _____

**Signature of Parent/Guardian** **Date**

## BY SIGNING AND INITIALING BELOW I AM AGREEING TO THE FOLLOWING:

_____ The School Nurse has my permission to be in communication with the prescribing physician regarding my child's medications on an as needed basis, to ensure the health and safety of my child during the school day.

_____ ***Daily prescription oral medications*** may be administered to my child during a field trip which occurs during normal school hours by a non-licensed staff member who has been delegated and trained and will be supervised by the School Nurse(s).

_____ To ensure my child's health and safety, relevant medical information may be shared with school staff working with my child or with emergency medical responders in the event of an emergency.

***X*** _____

**Signature of Parent/Guardian** **Date**