WAO HIGH SCHOOL HEALTH REGISTRATION —2018/2019

(ONE Form Per Student)

STUDENT _____ GRADE _____ DOB_____

IDENTIFY ANY MEDICAL DIAGNOSIS AND ALLERGIES BELOW THAT PERTAIN TO SCHOOL HOURS

	Medical DIAGNOSIS or **Physician** Diagnosed ALLERGY (food or other)	Describe the reaction if allergy ? (Rash? Hives? Difficulty Breathing?/.etc.)	PRESCRIPTION MEDICATION **School Hrs.** ***(NAME of Medication**)
1			
2			

ALL **ASTHMA STUDENTS MUST HAVE AN INHALER IN SCHOOL** with specific Instructions**!**

PERMISSION FOR EMERGENCY TREATMENT

**If the parent/guardian or emergency contact person listed in the office can NOT be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, I authorize and direct the school authorities to send the child listed on this form (properly accompanied) to the hospital/clinic most easily accessible for emergency treatment and authorize the emergency care facility to treat my dependent.

_____YES, I give permission for emergency treatment for my child.
_____NO, I do NOT give permission for emergency treatment for my child.

******PARENT SIGNATURE*** _____

PERMISSION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION/TREATMENT

**I GIVE PERMISSION FOR THE DESIGNATED NURSE or TRAINED STAFF TO GIVE MY CHILD THE FOLLOWING Over The Counter MEDICATIONS (per package instructions).

X CHECK *ALL THAT YOU GIVE PERMISSION FOR BELOW and* ***SIGN & DATE***

_____ Generic **Tylenol** 500mg 1 or 2
_____ Antibiotic Ointment for cuts
_____ Chapped Lip ointment
_____ 1% Hydrocortisone Cream per instructions
_____ Generic Ibuprofen 200gm 1 or 2
_____ Cough Drops
_____ Tums

**** All areas that are NOT checked off are considered a "DO NOT GIVE"!!**

*PARENT SIGNATURE*_____DATE _____

PRINT PARENT NAME _____