

## 2021-2022 Medical Information/Consent Form

### Student Information

Name: \_\_\_\_\_  
Last
First
Middle
Date of Birth

### Medical Information

Family Physician:		Phone:	
Family Dentist:		Phone:	
Insurance Info:			
Medical Conditions/Allergies	Yes/No	<i>If yes, Please Describe:</i>	
Asthma			
Diabetes			
Seizures/Epilepsy			
Heart Condition			
Food Allergies			
Medication Allergies			
Other			
Current Medication			
<i>Medical Consent: In the event your child experience a minor illness / minor discomfort, your signature below gives permission for the administration of medication if needed. Medication include: (Please check those you will allow the school to administer)</i>			
<input type="checkbox"/> Tylenol	<input type="checkbox"/> Motrin/Advil	<input type="checkbox"/> Benadryl	<input type="checkbox"/> Tums
<input type="checkbox"/> Kaopectate			
Does your child have a vision problem? <input type="checkbox"/> No	<input type="checkbox"/> Yes	Wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child have a hearing problem? <input type="checkbox"/> No	<input type="checkbox"/> Yes	Wear hearing Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Tubes? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Parent/Guardian Signature

*I understand that if no emergency contact is available, or the illness/injury is believed to be serious in nature, I give permission to have my child transported by ambulance to a hospital. I understand the cost of the transportation is the responsibility of the parent. I also understand that the information will be shared with WPCS staff and I authorize the school personnel to give any/all information and medical records regarding my child, so that proper and prompt treatment can be obtained.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_