



Watertown Christian School

15 12th Avenue Northeast
Watertown, South Dakota 57201
Phone: (605) 882-0949 Fax: (605) 882-5935

PERMISSION FOR MEDICATION AND/OR EMERGENCY TREATMENT

Family Name _____

Student Name(s) _____ Grade(s) _____

Health History: If you answer "yes" to any of these questions, please explain in the space provided.

Does your child have any of the following allergies?

- Bee Sting? NO YES _____
- Food? NO YES _____
- Medication? NO YES _____
- Other Allergies? NO YES _____

Does your child have a history of ear infections? NO YES _____

Does your child have asthma? NO YES _____

Does your child have diabetes? NO YES _____

Does your child have ADHD or ADD? NO YES _____

Does your child have skin disorders? NO YES _____

Does your child have seizure disorders? NO YES _____

Does your child have heart disorders? NO YES _____

Does your child have any illness/disorders not listed above? NO YES _____

Does your child wear glasses or contact lenses? NO YES _____

List any current routine medications your child is taking, and time of day taken.

_____ For _____ Times _____

_____ For _____ Times _____

_____ For _____ Times _____

Check the following items that are allowable for your child to receive while attending WCS:

(Provided by WCS)

- _____ Tylenol (recommended dosage appropriate for his/her age)
- _____ Ibuprofen (recommended dosage appropriate for his/her age)
- _____ Chloraseptic throat spray
- _____ Topical first aid ointment
- _____ Topical Hydrocortisone for insect bites, itchy skin, or redness
- _____ Ear Drops (Earache Relief)
- _____ Eye Drops (Visine or Allergy Relief)

**** ALL other medicines brought to WCS need to be in the office; in the original container with label and medicine form filled out. ****

Please complete other side

**Contact information if child becomes ill, needs to be taken home, and you are not available
(will be called in the order they are put):** Check if the same as last year

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

In the event services of a physician appears necessary, whom would you prefer the school to contact?

Check if the same as last year

1) Physician or Clinic Preference _____ Phone _____

2) Second Choice _____ Phone _____

In the event services of a dentist appears necessary, whom would you prefer the school to contact?

Check if the same as last year

1) Dentist or Clinic Preference _____ Phone _____

2) Second Choice _____ Phone _____

WCS will respond to an emergency according to the following:

- 1) Attempt to contact a parent, in all circumstances, upon/before transport to Emergency Room.
- 2) If necessary, will transport to Clinic or Emergency Room by ambulance.

Please list any changes in your family status this past year (births, deaths, parent/guardian changes, etc).

In the event physicians, other persons named on this card, or parents cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary, in their judgment, for the health of the aforesaid child. As parent, or guardian, I assume responsibility for the payment of ambulance, physician, or hospital fees. I give permission to medical personnel to provide emergency health care (Hospital personnel must contact parent/guardian by phone, or in person, before Emergency Room treatment can be given (with the exception of life-threatening situations). I understand that if my child is attending classes outside of Watertown Christian School during the course of a school day, these same permissions are also granted to the attending school (i.e. 5th/6th grade student attending Watertown Intermediate School or a 7th/8th grade student attending class at the Watertown Middle School).

***Parent signature** _____ **Date** _____

***Signature is the name(s) of the person(s), usually the parents or guardian, who can give legal permission for emergency treatment.**