WEBSTERVILLE CHRISTIAN ACADEMY WCA

Barre, Vermont **ANNUAL HEALTH UPDATE& EMERGENCY AUTHORIZATION FORM** **School Year 2022-2023**

PURPOSE: To enable parents/caregivers to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents/ caregivers must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent. The original form stays with the front office administration.

Student's Full Name

_____ _____

Last **First** **Middle initial** **Age** **Grade**

Student's Doctor's Name:	**Phone:**
What was the date of your child's last comprehensive annual well care visit* received in their doctor's office? **Date:_____**	
Doctor's Signature:	**Date:**
Prescription Medication Information: *Any medication that needs to be dispensed at school must have a matching prescription label and doctor's order.*	
Student's Dentist:	**Phone:**
Hospital Preference:	**Phone:**

*** A comprehensive well-care (physical) visit is not a sick appointment**

STUDENT'S MEDICAL HISTORY:

- **ALLERGIES: Serious- Requires epinephrine: (please describe) _____**

_____

- **ASTHMA:** Has a doctor, nurse, or other health professional EVER said that your child has asthma?
  _____ Yes _____ No _____ Don't know/not sure
  - **If yes, does your child STILL have asthma?**
  _____ Yes _____ No _____ Don't know/not sure
- **DIABETES? Yes ____ NO _____**
- **SEIZURES? Yes ____ NO _____**
- **USE CORRECTIVE LENSES? YES_____ NO _____ HEARING AIDS? YES _____ NO _____**

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, WHEN I CAN NOT BE REACHED: I hereby give consent to transport my child for medical care and authorize the providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian _____ Date _____

WEBSTERVILLE CHRISTIAN ACADEMY WCA

Please indicate if student has had or is currently under treatment for any of the following conditions:

_____BLEEDING DISORDERS _____
_____EAR/HEARING PROBLEMS _____
_____HEART PROBLEMS
_____HIGH BLOOD PRESSURE
_____MENTAL HEALTH CONDITION and treatment (Please explain):_____
_____
_____MUSCULAR WEAKNESS OR PARALYSIS
_____MIGRAINE HEADACHES
_____OTHER allergies: (Please list) _____ _____

****Please be aware that any student who presents with a fever of 100◦F or higher, will be required to be picked up from school as soon as possible. Students may return to school ONLY if they have had no temperature for 24hrs. WITHOUT a fever reducer (Tylenol, motrin).**

Siblings: [this section is for optional inclusion in school emergency health form]

Last Name	First Name	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Permission for Over the Counter Medications (OTC). My child has permission to receive the following medications provided by me, the parent/guardian, at school according to the instructions on the manufacturer's label. OTC limited to Ibuprofen, Tylenol, Advil, Children's Lozenges in unopened containers in small quantities.

_____
_____

By signing this authorization the parent/guardian is agreeing that the above medication is the correctly prescribed medication for the above named student. The parent/guardian also gives Websterville Christian Academy permission to dispense the above medication to the above named student as prescribed by the above named physician.

_____	_____	_____
Signature – Parent or Guardian	**Relationship to student**	**Date**
_____	_____	_____
Signature – Parent or Guardian	**Relationship to student**	**Date**

317 VINE STREET, BARRE VT 05641 • P: (802) 622-0298 • WCAVT.ORG • WCAOFFICE@WCAVT.ORG 11/28/22

WEBSTERVILLE CHRISTIAN ACADEMY

WCA

WCA Medication Authorization

2022-2023

Student Name

** FOR WCA USE ONLY **

(Medication Log)

Grade

Medication	Dosage	Comments	Date	Time	Initials

Initials	Signature	Title