Wheeling Country Day School
Health and Permission Forms

PLEASE PRINT OR TYPE

Medical Information For: _____
Last Name First Name Middle Name

Date of Birth: _____ _____ _____
Month Day Year

My child, _____, has permission to participate in daily physical indoor and outdoor activities.

_____
Signature of Parent

EMERGENCY MEDICAL AUTHORIZATION

In the event that I or any other legally responsible person cannot be contacted within an appropriate amount of time, I hereby authorize a representative of Wheeling Country Day School to act on my behalf in securing emergency medical services for my child. Please note the following important medical information.

My child has:

Medical Condition: _____

Known Allergies: _____

Food Restrictions: _____

Please note any medical conditions that would be pertinent to school personnel: _____

_____

_____

Person(s) to contact who can pick up if parents are not available:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Student Name: _____

Physician: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Mother's Name: _____ Day Phone: _____

Father's Name: _____ Day Phone: _____

I hereby give permission to the faculty/staff at Wheeling Country Day School to administer the following products according to the manufacturer's instructions or as otherwise specified. No attempt need be made to contact me before rendering this assistance.

Please √ the following you give permission to be administered:

☐ Sting Treatment	☐ Calamine Lotion	☐ Eye Drops	☐ Tums
☐ Benadryl	☐ Anti-Itch Cream	☐ Vapor Rub	☐ Children's Ibuprofen
☐ Triaminic – Cold/Cough	☐ Antibiotic Ointment	☐ Ice Bag	☐ Children's Tylenol
☐ Vaseline	☐ First Aid Cream	☐ Band-aids	☐ Children's Advil
☐ Saline Solution	☐ Skin Lotion	☐ Oral Anesthetic Gel	☐ Children's Motrin
☐ Cough Drops	☐ Cough Strips	☐ Bandages	☐ Splinter Removal
☐ Peroxide	☐ Stomach Relief Tablets	☐ Sore Throat Spray	☐ Eye Wash (Water)

Others: _____

As parent/guardian, I give consent to have my child receive first-aid by Wheeling Country Day School faculty and/or staff; if necessary, be transported to receive emergency care; and, for the emergency contact person listed to act on my behalf until I am available.

Signed this _____ day of _____, 20__ for as long as my child remains at Wheeling Country Day School or until I/We rescind the permission.

_____ _____

Parent/Guardian Signature *Relationship*

Please attach a copy of your child's Birth Certificate and up-to-date immunization records.

I do not want Wheeling Country Day School to administer any non-emergency aid to my child.

_____ _____ _____

Parent/Guardian Signature ***Relationship*** ***Date***