

HEALTH CONDITIONS:

Check any current health conditions that may require attention during the school day. Please be specific in your answers.

Allergies _____
 Foods _____
 Medicines/Latex _____
 Bee Sting/Insect Bite _____
 Asthma _____
 Blood Disorders/hemophilia/immunosuppressed) _____
 Diabetes (if medicated, list below) _____
 Hearing Problems/Hearing aid(s) _____
 Heart Problems (be specific) _____
 Physical Disability (be specific) _____
 Respiratory (be specific) _____
 Seizures _____
 Vision Problems (be specific) _____ Wears Contacts _____ Wears Glasses _____
 Other conditions not listed here: _____

MEDICATIONS:

Will your child need to take medication while at the Lock-In? YES NO If YES, please complete:

Medication	Dosage	Time	Prescribed by/for (condition)

List all medications and dosages your child receives on a daily, continual basis:

Medication	Dosage	Time	Prescribed by/for (condition)

PARENT AUTHORIZATION

I authorize Wolf River Lutheran High School personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Medication must be registered with the Administrator, his/her designee, or the school secretary. It must be in the ORIGINAL, UNOPENED, SEALED CONTAINER and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

I also authorize the staff of WRLHS to administer OTC (over the counter) pain medications as needed (Acetaminophen/Ibuprofen), should my child require their use for pain.

 Parent Signature Date