WCCS Authorization for Administration of First Aid

Name_____ Phone_____ Grade_____
Address_____City_____Zip_____
Father's Name_____ Work/Cell #_____
Mother's Name_____ Work/Cell #_____
Emergency Contact Other Than Parent_____ Phone_____
Family Doctor_____ Phone_____

MEDICAL ALERT: ( )Yes ( ) No If yes, Please identify:_____

Allergies:_____

The following first aid/medication may be given or applied by WCCS staff. Please check all appropriate responses:

( ) Acetaminophen (Tylenol) ( ) Robitussin Cough Syrup ( ) Benadryl
( ) Ibuprofen (Motrin) ( ) Dimetapp ( ) Visine
( ) Neosporin Ointment ( ) Anti-Itch Cream ( ) Hydrogen Peroxide
( ) Pepto-Bismol ( ) Imodium

_____ _____
Signature of Parent/Guardian Date

FIRST AID ADMINISTRATION RECORD

Date:	Aid Given:	Time:	Personnel Initials:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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